Actor portrayal.

the weigh forward

MODULE 2

Understanding the evolution of AOM access

and calculating your company's obesity numbers

Government health plans have promoted increased coverage for obesity treatment, but access is still variable

Medicare and Medicaid
2024

In 2024, CMS clarified that AOMs that receive FDA approval for additional medically accepted indications must be covered by Medicaid and considered Part D drugs for that specific use. AOMs that receive FDA approval for chronic weight management alone would not be considered a Part D drug but may be covered by certain state Medicaid programs.[1,2]

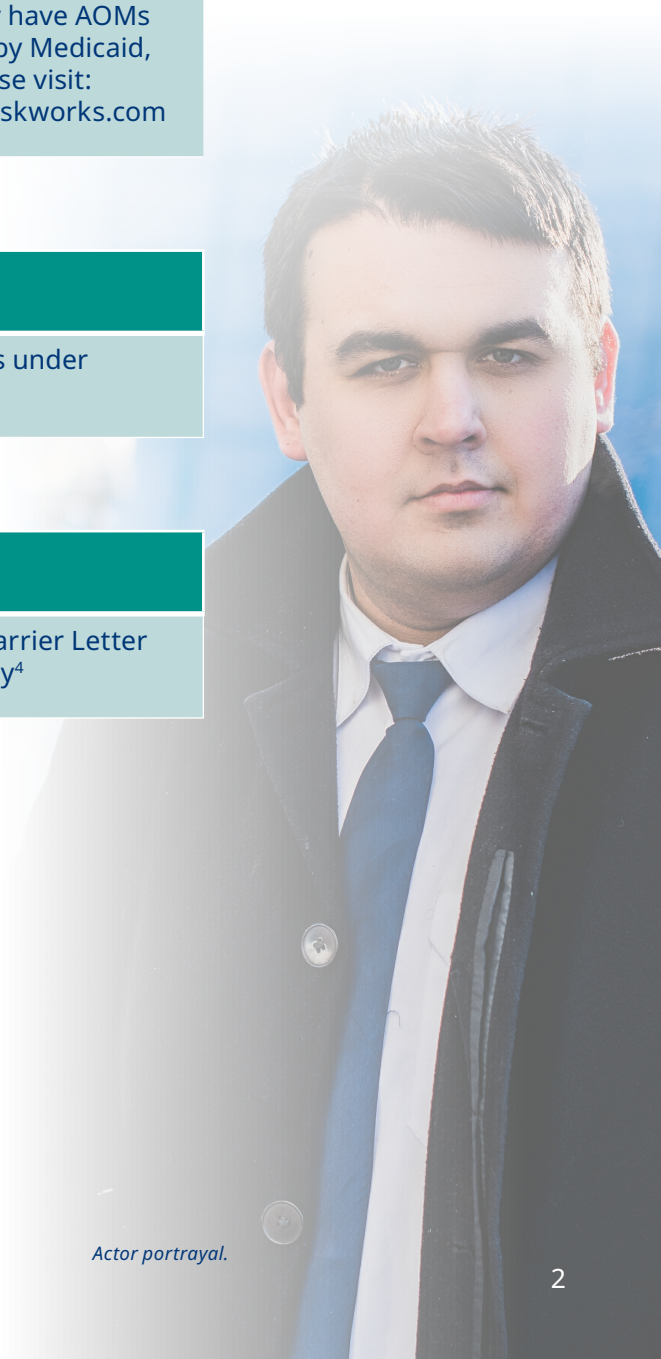
To see which states currently have AOMs covered by Medicaid, please visit: novonordiskworks.com

National Defense Authorization Act
2017

Authorization of the coverage of weight-reduction drugs under the TRICARE pharmacy benefit[3]

US Office of Personnel Management
January 18, 2023

Updated Federal Employee Health Benefit (FEHB) Program Carrier Letter promotes coverage that supports pharmacotherapy[4]



CMS=Centers for Medicare & Medicaid Services; FDA=U.S. Food and Drug Administration.

Actor portrayal.

The FEHB's guidance has changed over time, including a recent update regarding the coverage of AOMs[4]

Nutrition and exercise are primary options

Carriers should offer adequate coverage for AOMs

2011	2012	2013	2014	2019	2022	2023
Propose specific services to reduce the incidence of obesity	Offer programs to help members attain and maintain a healthy weight	Provide guidance on bariatric surgery	May not exclude weight-reduction drugs from coverage on the basis of obesity being a "lifestyle condition" or obesity treatment being "cosmetic"	Must cover screening and intensive behavioral interventions if referred	May not exclude AOMs based on a benefit exclusion or a carve-out	Provide adequate coverage of FDA-approved AOMs to meet patient needs

FEHB CARRIER LETTER SUMMARY

The FEHB Program Carrier Letter, released in January 2023, emphasized the importance of covering AOMs[4]

The FEHB Program Carrier Letter instructs all federal health benefit carriers to update their medical policies to reflect new mandates involving the treatment of obesity with the **goal of having all carriers provide adequate coverage of AOMs**

All carriers are required to provide **non-discriminatory access** to safe and clinically appropriate AOMs as a standard listing on their formulary, and must provide access to a range of clinically appropriate AOMs as standard listing

If utilization management edits or approaches are employed, the process and evidence-based criteria for coverage must be transparent, readily accessible, and follow OPM required turnaround timelines for standard and expedited reviews

As new AOMs come to market, federal health benefit carriers are now **expected and required** to conduct **ongoing evaluations** of AOMs, as they are FDA-approved, and to update their coverage accordingly

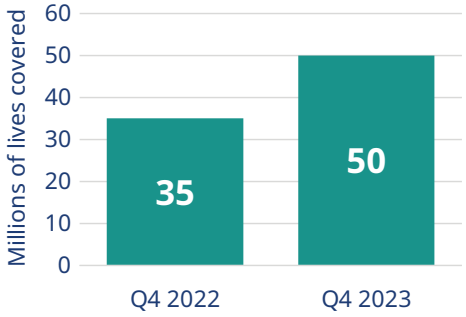
Actor portrayal.

Payers and employers now have a wider range of AOM options when building comprehensive weight-management and health programs[5]

The current Endocrine Society Clinical Practice Guidelines emphasize the need to[5]:

- Manage obesity as a **medical condition**
- **Recommend pharmacotherapy or bariatric surgery** in addition to behavioral modification in appropriate patients
- Highlight how AOMs may **amplify adherence to behavior change**

Millions of people with obesity have gained coverage for AOMs[6]



The estimated number of people with obesity with AOM coverage increased by 15 million lives from quarter 4 in 2022 to quarter 4 in 2023.[6]

Expansion of AOM coverage is likely in the next few years

Society for Human Resource Management (SHRM)[7]	Gallagher Benefit Services[8]	Pharmaceutical Strategies Group[9]
A 2023 healthcare firm (Accolade) survey of 500 employers found that: • **43% of employers** plan to cover certain AOMs in 2024 • **81% of human resource decision-makers** report that their employees would be interested in certain AOM medications	2022 employer market trends report using data from 97 employers with over 5000 employees, 30 employer health coalitions, and interviews conducted with 8 benefit executives and 3 health coalition leaders. • **21% are open to providing coverage** for weight-reduction medications in the future	Survey of 149 employers and health plans conducted in February and March 2023. • **28% of employers were considering adding AOMs** in the next few years

The use of AOMs as part of a comprehensive obesity-management plan is supported by third-party guidelines such as those put forth by the AHA/ACC/TOS and AACE/ACE, as well as by American Medical Association recommendation.[10-12,a]

[a]All third-party guidelines recommend the addition of lifestyle changes for comprehensive obesity management.[10,11]

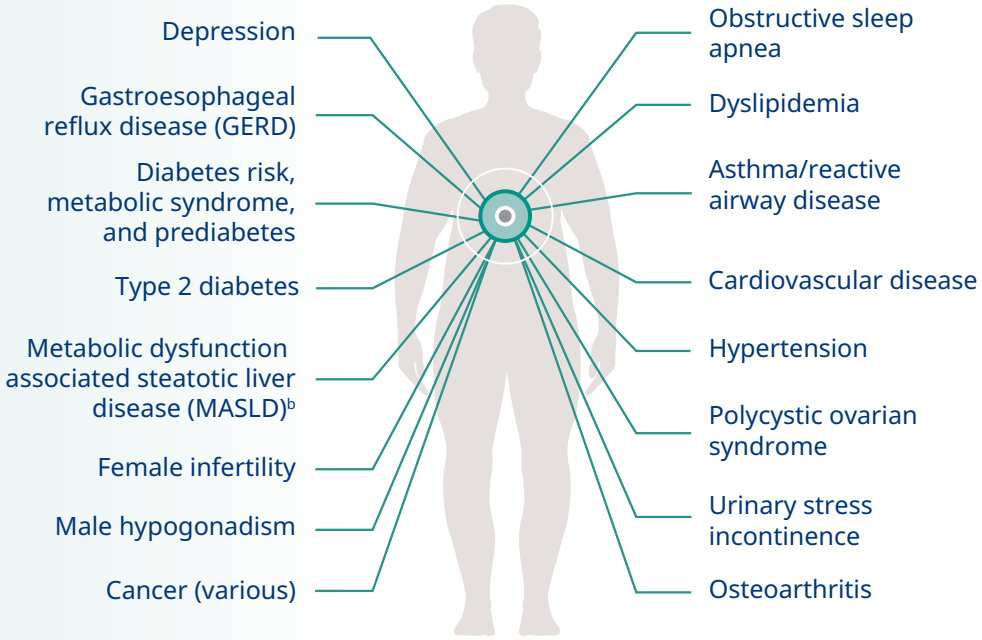
AACE=American Association of Clinical Endocrinologists; ACC=American College of Cardiology; ACE=American College of Endocrinology; AHA=American Heart Association; TOS=The Obesity Society.

Actor portrayal.

Know your numbers, know your risk

Obesity has a significant clinical and economic impact because it is often associated with many comorbidities.[11] For the health of people affected, it is important to know the combined health risks and the relationship between those risks.

There are multiple comorbidities associated with obesity. Some of the ones you may see in your claims data are[11,13,a]:



Consult your EBC or PBM to request a data summary of **electronic health records (EHRs)** to determine the proportion of your employee population at highest risk of weight-related comorbidities[14]

- Utilizing longitudinal weight trajectory and other aggregated employee clinical data provided by your EBC/PBM can identify the employee population that could most benefit from lifestyle, pharmacological, or surgical interventions, which may help you determine appropriate benefit offerings

You may not be seeing obesity coded in your claims data.

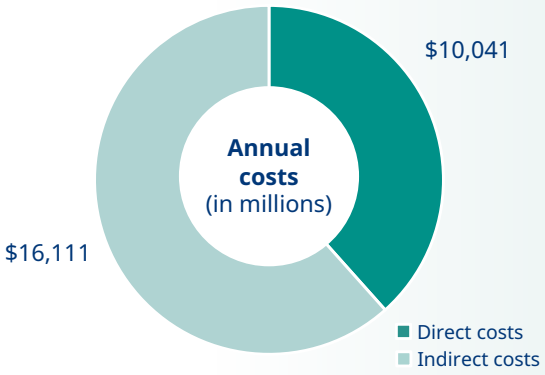
[a]The above list is not exhaustive and is intended to illustrate only a range of key complications.
[b]Formerly known as nonalcoholic fatty liver disease (NAFLD).

Estimated costs of asthma based on increased risks associated with obesity

Based on national adult asthma prevalence of 8% and population-attributable risk of 20.4%[15,16,a]:

Company size	Population with asthma attributable to obesity
5000	82
10,000	163
50,000	816

The total costs for asthma attributable to obesity are $26,152 million USD[15,17,b,c]

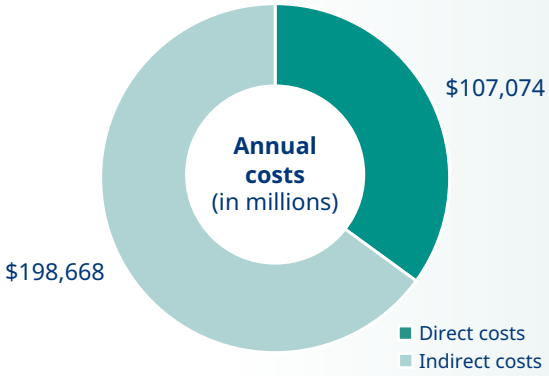


Estimated costs of type 2 diabetes based on increased risk associated with obesity

Based on national type 2 diabetes prevalence of 10% and population-attributable risk of 50.7%[15,18]:

Company size	Population with type 2 diabetes attributable to obesity
5000	254
10,000	507
50,000	2535

The total costs for type 2 diabetes attributable to obesity are $305,742 million USD[15,17,b,c]



Estimated costs of dyslipidemia based on increased risk associated with obesity

Based on national dyslipidemia prevalence of 29.4% and population-attributable risk of 19.3%[15,18]:

Company size	Population with dyslipidemia attributable to obesity
5000	284
10,000	567
50,000	2837

The total **direct cost for dyslipidemia** attributable to obesity is **$16,156 million USD**[15,17,b,c]

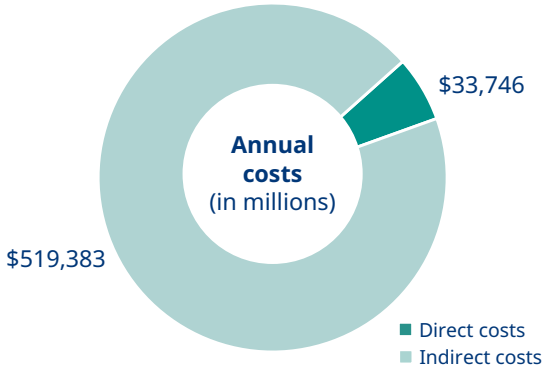
[a]Prevalence data is based on the 2021 National Health Interview Survey.
[b]2018 costs adjusted for inflation in 2023.
[c]Direct costs were medical treatment for the condition; indirect costs were lost workdays, calculated as lost employee output.
USD=United States dollars.

Estimated costs of hypertension based on increased risk associated with obesity

Based on national hypertension prevalence of 30% and population-attributable risk of 32.4%[15,18]:

Company size	Population with hypertension attributable to obesity
5000	486
10,000	972
50,000	4860

The total costs for hypertension attributable to obesity are $553,129 million USD[15,17,a,b]

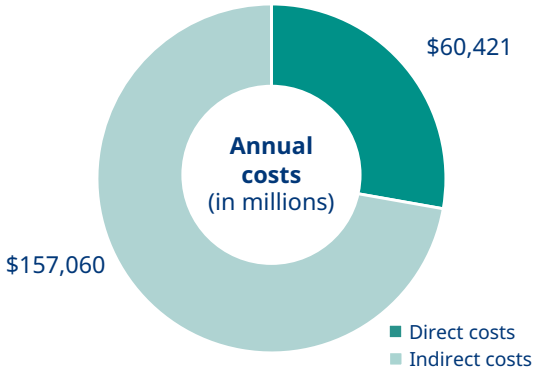


Estimated costs of osteoarthritis based on increased risk associated with obesity

Based on national osteoarthritis prevalence of 9.8% and population-attributable risk of 46.9%[15,19,20]

Company size	Population with osteoarthritis attributable to obesity
5000	230
10,000	460
50,000	2298

The total costs for osteoarthritis attributable to obesity are $217,480 million USD[15,17,a,b]

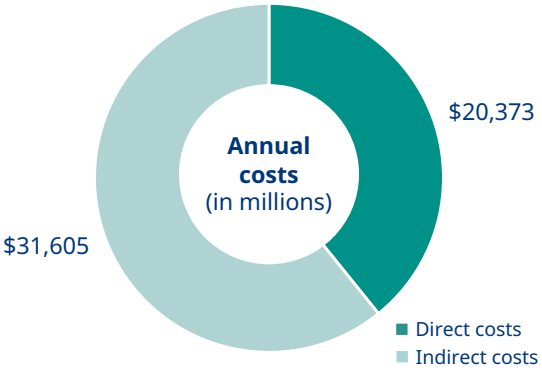


Estimated costs of coronary heart disease based on increased risk associated with obesity

Based on national coronary heart disease prevalence of 3.4% and population-attributable risk of 22.6%[15,18]:

Company size	Population with coronary heart disease attributable to obesity
5000	38
10,000	77
50,000	384

The total costs for coronary heart disease attributable to obesity are $51,979 million USD[15,17,a,b]



[a]2018 costs adjusted for inflation in 2023.

[b]Direct costs were medical treatment for the condition; indirect costs were lost workdays, calculated as lost employee output.

USD=United States dollars.

Action steps for employers

Work with your EBC or PBM to:

Verify that obesity measurement is part of your organization's annual workforce health risk assessments.

Measure obesity along with other common and easy-to-recognize comorbidities of obesity (dyslipidemia, type 2 diabetes, hypertension, and osteoarthritis).

Review the prevalence of obesity and its related comorbidities within your organization to understand the total cost impact of direct medical expenses, disability, and absenteeism/presenteeism.

Evaluate your organization's obesity-management strategy to determine opportunities to maximize effectiveness, such as:

- Adding and improving AOM coverage as part of your benefit plan **(see Module 3)**
- Measure the success of adding AOM coverage to your benefit plan **(see Module 4)**
- Resources from Novo Nordisk to support obesity management initiatives for your organization and its employees **(see Module 4)**

Actor portrayal.

Ensure to capture obesity by coding correctly: ICD-10 codes associated with obesity[21]

Commonly reported codes

Description	Code
Obesity, unspecified	E66.9
Morbid (severe) obesity due to excess calories	E66.01

Other obesity-related codes

Description	Code
Obesity due to excess calories	E66.0
Morbid (severe) obesity due to excess calories	E66.01
Other obesity due to excess calories	E66.09
Drug-induced obesity	E66.1
Morbid (severe) obesity with alveolar hypoventilation	E66.2
Overweight	E66.3
Other obesity	E66.8

Counseling codes

Description	Code
Dietary counseling and surveillance	Z71.3
Other specified counseling	Z71.89

Disclaimer: Novo Nordisk does not guarantee the accuracy or propriety of any billing or coding information contained in this resource and does not recommend the use of any specific codes for the treatment of an individual patient.

ICD-10=International Classification of Diseases, Tenth Revision.

Coding for BMI ≥40 kg/m²

Description	Code
Body mass index (BMI) 40.0–44.9, adult	Z68.41
Body mass index (BMI) 45.0–49.9, adult	Z68.42
Body mass index (BMI) 50.0–59.9, adult	Z68.43
Body mass index (BMI) 60.0–69.9, adult	Z68.44
Body mass index (BMI) 70 or greater, adult	Z68.45

Screening codes

Description	Code
Encounter for screening for diabetes mellitus	Z13.1
Encounter for screening for nutritional, metabolic, and other endocrine disorders	Z13.2
Encounter for screening for nutritional disorder	Z13.21
Encounter for screening for metabolic disorder	Z13.22
Encounter for screening for lipoid disorders	Z13.220
Encounter for screening for other metabolic disorders	Z13.228
Encounter for screening for other suspected endocrine disorders	Z13.29

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