

OBESITY TREATMENT AGENTS PRIOR AUTHORIZATION FORM

(form effective 1/8/2024)



Fax to PerformRxSM at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774**.

PRIOR AUTHORIZATION REQUEST INFORMATION		
<input type="checkbox"/> New request <input type="checkbox"/> Renewal request	# of pages:	
Prescriber name:		
Specialty:	NPI:	State license #:
Street address:	City/state/zip:	
Phone:	Fax:	
Name of office contact:		
Contact's phone number:	LTC facility contact/phone:	
Beneficiary name:	Beneficiary ID#:	Date of birth:

CLINICAL INFORMATION		
Drug requested:		
Strength & package size:	Quantity:	Refills:
Directions:		
Diagnosis (submit documentation):	DX code (required):	
For a non-preferred Obesity Treatment Agent , does the beneficiary have a history of trial and failure of or a contraindication or an intolerance to the preferred Obesity Treatment Agent appropriate for the beneficiary's diagnosis or indication? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Submit documentation.
Does the beneficiary have any contraindications to the requested medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Submit documentation.
ATTESTATION from the prescriber: Was beneficiary recently counseled about lifestyle changes and behavior modifications such as a healthy diet and increased physical activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Complete all sections that apply to the beneficiary and this request. Check all that apply and submit documentation for each item.

INITIAL REQUESTS			
1. The beneficiary is 18 years of age or older: Pre-treatment weight: _____ Pre-treatment BMI: _____			
<input type="checkbox"/> Has a BMI greater than or equal to 30 kg/m2			
<input type="checkbox"/> Has a BMI greater than or equal to 27 kg/m2 and less than 30 kg/m2 and at least one of the following weight-related comorbidities:			
<input type="checkbox"/> dyslipidemia	<input type="checkbox"/> metabolic syndrome	<input type="checkbox"/> prediabetes	<input type="checkbox"/> other (list):
<input type="checkbox"/> hypertension	<input type="checkbox"/> obstructive sleep apnea	<input type="checkbox"/> type 2 diabetes	
<input type="checkbox"/> Is a candidate for treatment based on degree of adiposity, waist circumference, history of bariatric surgery, BMI exceptions for beneficiary's ethnicity, etc. and has at least one of the following weight-related comorbidities:			
<input type="checkbox"/> dyslipidemia	<input type="checkbox"/> metabolic syndrome	<input type="checkbox"/> prediabetes	<input type="checkbox"/> other (list):
<input type="checkbox"/> hypertension	<input type="checkbox"/> obstructive sleep apnea	<input type="checkbox"/> type 2 diabetes	
2. The beneficiary is less than 18 years of age:			
Pre-treatment BMI: _____ Pre-treatment BMI z-score: _____			
<input type="checkbox"/> Has a BMI in the 95th percentile or greater standardized for age and sex based on current CDC charts			
3. Request is for <u>Evekeo (amphetamine) ODT/tablet</u>:			
<input type="checkbox"/> Was assessed for potential risk of misuse, abuse, and/or addiction based on family and social history			
<input type="checkbox"/> Was educated regarding the potential adverse effects of stimulants, including the risk of misuse, abuse, and addiction			
<input type="checkbox"/> Has a history of trial and failure of or a contraindication or an intolerance of all other Obesity Treatment Agents (preferred and non-preferred)			
<input type="checkbox"/> Has prescriber documentation explaining why Evekeo (amphetamine) is needed and a plan for tapering			
<input type="checkbox"/> For a beneficiary with a history of substance dependency, abuse, or diversion:			
<input type="checkbox"/> Has results of a recent UDS for licit & illicit drugs with the potential for abuse (including specific testing for oxycodone, fentanyl, and tramadol) that is consistent with prescribed controlled substances			

RENEWAL REQUESTS	
1. All requests: <input type="checkbox"/> The dose of the requested medication is currently being titrated <input type="checkbox"/> The beneficiary is experiencing clinical benefit with the requested medication	
2. The beneficiary is 18 years of age or older: Pre-treatment weight: _____ Current weight: _____	
3. The beneficiary is less than 18 years of age: Pre-treatment BMI: _____ Current BMI: _____	
Pre-treatment BMI z-score: _____ Current BMI z-score: _____	
4. Request is for <u>Evekeo (amphetamine) ODT/tablet</u>:	
<input type="checkbox"/> Has prescriber documentation explaining why Evekeo (amphetamine) is needed and a plan for tapering (submit documentation)	
<input type="checkbox"/> For a beneficiary with a history of substance dependency, abuse, or diversion:	
<input type="checkbox"/> Has results of a recent UDS for licit & illicit drugs with the potential for abuse (including specific testing for oxycodone, fentanyl, and tramadol) that is consistent with prescribed controlled substances	

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION	
Prescriber signature:	Date:

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