Prior Authorization Request Form for Obesity Treatment Agents

FAX this completed form to (844) 205-3386

OR Mail requests to: PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	
Strength & package size/quantity/refills:	
Additional strengths / quantity for each / refills for each to allow for dose titration:	
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 Agents 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.*	☐Yes ☐No *Submit documentation.*
Does the beneficiary have any contraindications to the requested medication?	☐Yes ☐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?	☐Yes ☐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: _____

☐ Has a BMI greater than or equal to 30 kg/m^2

☐ Has a BMI greater than or equal 27 kg/m^2 and less than 30 kg/m^2 and at least one of the following weight-related comorbidities:

- ☐ dyslipidemia
- ☐ hypertension
- ☐ metabolic syndrome
- ☐ other (list): _____
- ☐ obstructive sleep apnea
- ☐ prediabetes
- ☐ type 2 diabetes
- _____

☐ 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:

- ☐ dyslipidemia
- ☐ hypertension
- ☐ metabolic syndrome
- ☐ other (list): _____
- ☐ obstructive sleep apnea
- ☐ prediabetes
- ☐ type 2 diabetes
- _____

2. The beneficiary is less than 18 years of age:

Pre-treatment BMI: _____ Pre-treatment BMI z-score: _____

☐ Has a BMI in the 95th percentile or greater standardized for age and sex based on current CDC charts

3. Request is for Evekeo (amphetamine) ODT/tablet:

☐ Was assessed for potential risk of misuse, abuse, and/or addiction based on family and social history

☐ Was educated regarding the potential adverse effects of stimulants, including the risk of misuse, abuse, and addiction

☐ Has a history of trial and failure of or a contraindication or an intolerance of all other Obesity Treatment Agents (preferred and non-preferred)

☐ Has prescriber documentation explaining why Evekeo (amphetamine) is needed and a plan for tapering

☐ **For a beneficiary with a history of substance dependency, abuse, or diversion:**

- ☐ 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:

☐ The dose of the requested medication is currently being titrated

☐ 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 Evekeo (amphetamine) ODT/tablet:

☐ Has prescriber documentation explaining why Evekeo (amphetamine) is needed and a plan for tapering (*submit documentation)*

☐ **For a beneficiary with <u>a history of substance dependency, abuse, or diversion</u>:**

☐ 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

ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION

PLEASE <u>FAX</u> COMPLETED FORM WITH <u>REQUIRED CLINICAL DOCUMENTATION</u> TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

PA Department will respond via fax or phone within 24 hours.

Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)