

OBESITY TREATMENT AGENTS PRIOR AUTHORIZATION FORM (form effective 1/9/2023)

**This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
 Allow at least 24 hours for review.**

Prior authorization guidelines for **Obesity Treatment Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request <input type="checkbox"/> 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:
Directions:		
Diagnosis (submit documentation):		Dx code (required):
For a non-preferred Anti-Obesity Agent , does the beneficiary have a history of trial and failure of or a contraindication or an intolerance to the preferred Anti-Obesity 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.		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>
For a controlled substance Obesity Treatment Agent (e.g., phentermine, Qsymia, etc.) , did the prescriber or prescriber's delegate search the PDMP to review the beneficiary's controlled substance prescription history before issuing this prescription for the requested agent?		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>
Does the beneficiary have any contraindications to the requested medication?		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>
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: _____

- Has a BMI greater than or equal to 30 kg/m²
 Has a BMI greater than or equal 27 kg/m² and less than 30 kg/m² and at least one of the following comorbidities:

<input type="checkbox"/> dyslipidemia	<input type="checkbox"/> obstructive sleep apnea
<input type="checkbox"/> hypertension	<input type="checkbox"/> prediabetes
<input type="checkbox"/> metabolic syndrome	<input type="checkbox"/> type 2 diabetes
<input type="checkbox"/> other (list): _____	_____
- Is a candidate for treatment based on degree of adiposity, waist circumference, history of bariatric surgery, BMI exceptions for beneficiary's ethnicity, etc. and at least one of the following comorbidities:

<input type="checkbox"/> dyslipidemia	<input type="checkbox"/> obstructive sleep apnea
<input type="checkbox"/> hypertension	<input type="checkbox"/> prediabetes
<input type="checkbox"/> metabolic syndrome	<input type="checkbox"/> type 2 diabetes
<input type="checkbox"/> other (list): _____	_____

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
 Has a BMI in the 85th percentile or greater standardized for age and sex based on current CDC charts and at least one of the following comorbidities:

<input type="checkbox"/> dyslipidemia	<input type="checkbox"/> obstructive sleep apnea
<input type="checkbox"/> hypertension	<input type="checkbox"/> prediabetes
<input type="checkbox"/> metabolic syndrome	<input type="checkbox"/> type 2 diabetes
<input type="checkbox"/> other (list): _____	_____
- Is a candidate for treatment based on degree of adiposity, previous bariatric surgery, etc. and at least one of the following comorbidities:

<input type="checkbox"/> dyslipidemia	<input type="checkbox"/> obstructive sleep apnea
<input type="checkbox"/> hypertension	<input type="checkbox"/> prediabetes
<input type="checkbox"/> metabolic syndrome	<input type="checkbox"/> type 2 diabetes
<input type="checkbox"/> other (list): _____	_____

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

- The beneficiary 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 and/or a positive response to treatment 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 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

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:

Date:

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.