DEPARTMENT OF HEALTH SERVICES
Division Medicaid Services
F-00163 (01/2021)

STATE OF WISCONSIN
Wis. Admin. Code § DHS 107.10(2)

FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR ANTI-OBESITY DRUGS

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Anti-Obesity Drugs Instructions, F-00163A. Providers may refer to the Forms page of the ForwardHealth Portal at https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms for the completion instructions.

Providers may call the Drug Authorization and Policy Override Center at 800-947-9627 with questions.

SECTION I – MEMBER INFORMATION

1. Name – Member (Last, First, Middle Initial)

2. Member ID Number	3. Date of Birth – Member

SECTION II – PROVIDER INFORMATION

4. Name – Prescriber	5. National Provider Identifier – Prescriber

6. Address – Prescriber (Street, City, State, Zip+4 Code)

7. Phone Number – Prescriber

8. Name – Billing Provider	9. National Provider Identifier – Billing Provider

SECTION III – PRESCRIPTION INFORMATION

10. Drug Name	11. Drug Strength
12. Date Prescription Written	13. Directions for Use

14. Refills

SECTION IV – CLINICAL INFORMATION

15. Diagnosis Code and Description

16. Height – Member (Inches)	17. Weight – Member (Pounds)
18. Date Member's Weight Was Measured	19. Body Mass Index (BMI) – Member (lb / in^2)
20. Goal Weight – Member (Pounds)	BMI = $\frac{703 \times (\text{weight in pounds})}{(\text{height in inches})^2}$

DT-PA085-085

For an initial PA request, the prescriber should complete Sections IV A and IV B. For a renewal PA request, the prescriber should complete Section IV A.

SECTION IV A – INITIAL AND RENEWAL COVERAGE REQUIREMENTS

21. Enter the member's age.

Note: Members must be 16 years of age, except for Xenical. Members must be 12 years of age or older to take Xenical.

22. Is the member pregnant or nursing? ☐ Yes ☐ No

23. Does the member have a history of an eating disorder (for example, anorexia, bulimia, or binge eating disorder)? ☐ Yes ☐ No

24. Has the prescriber evaluated the member and determined that they do not have any medical or medication contraindications to treatment with the anti-obesity drug being requested? ☐ Yes ☐ No

25. Does the member have a medical history of substance abuse or misuse? ☐ Yes ☐ No

SECTION IV B – INITIAL COVERAGE REQUIREMENTS

26. BMI Requirements (Check A or B.)

A. ☐ The member has a BMI greater than or equal to 30.

B. ☐ The member has a BMI greater than or equal to 27 but less than 30 **and** has two or more of the following risk factors.
Check the member's current risk factors:

- ☐ Coronary Heart Disease
- ☐ Dyslipidemia
- ☐ Hypertension
- ☐ Sleep Apnea
- ☐ Type II Diabetes Mellitus

27. Has the member participated in a weight loss treatment plan (for example, nutritional counseling, an exercise regimen, or a calorie-restricted diet) in the past six months, and will the member continue to follow this treatment plan while taking an anti-obesity drug? ☐ Yes ☐ No

If yes, describe the treatment plan in the space provided.

SECTION V – AUTHORIZED SIGNATURE

28. **SIGNATURE** – Prescriber	29. Date Signed – Prescriber

SECTION VI – ADDITIONAL INFORMATION

30. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.

Reset Form