Prior Authorization Drug Attachment for Weight Management Agents

Instructions

Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Weight Management Agents Instructions, F-00163A. Prescribers or their designees may refer to the Forms page of the ForwardHealth Portal (the Portal) at forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms for the completion instructions.

Prescribers or their designees are required to have a completed Prior Authorization Drug Attachment for Weight Management Agents form signed and dated before submitting a prior authorization (PA) request on the Portal, by fax, by mail, or by contacting the Drug Authorization and Policy Override (DAPO) Center. A prescriber or their designee should have all PA information completed before calling the DAPO Center to obtain PA.

Prescribers and pharmacy providers may call Provider Services 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. Address – Prescriber (Street, city, state, ZIP+4 code):

_____

6. Phone number – Prescriber:_____

7. National Provider Identifier (NPI) – Prescriber:_____

8. Name – Billing provider:_____

9. NPI – Billing provider:_____

Section III – Prescription information

10. Drug name:_____ 11. Drug strength:_____

12. Date prescription written:_____ 13. Refills:_____

14. Directions for use:_____

Section IV – Clinical information

15. Diagnosis code and description:

16. Member's current body mass index (BMI):_____ (lb / in^2)

17. Date member's BMI was measured (Must be within the past three months.):_____

18. 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:

- ❑ Dyslipidemia
- ❑ Hypertension
- ❑ Sleep apnea
- ❑ Type 2 diabetes mellitus
- ❑ Cardiovascular disease supported by a history of at least one of the following (Check all that apply.):
  - ❑ Myocardial infarction (heart attack)
  - ❑ Coronary revascularization
  - ❑ Angina pectoris
  - ❑ Stroke
  - ❑ Intermittent claudication with an ankle-brachial index of less than or equal to 0.9
  - ❑ Peripheral arterial revascularization due to atherosclerotic disease
  - ❑ Amputation due to atherosclerotic disease

19. Has the member agreed to follow a reduced-calorie diet and increase their physical activity?

❑ Yes ❑ No

Section V – Authorized signature

20. Signature – Prescriber:_____

21. Date signed – Prescriber:_____

Section VI – Additional information

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

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