Michigan Department of Health and Human Services (MDHHS)
Prior Authorization Request
Xenical® (*orlistat*)

All information on this form must be addressed. Incomplete forms will be returned only once for missing information. Mark as 'N/A' if no information is available or does not apply. Issues that remain blank after being returned once will receive a denial and will not qualify for MDHHS physician review until completed or clearly marked 'N/A'.

Beneficiary Information

LAST NAME:

FIRST NAME:

MEDICAID NUMBER:

DATE OF BIRTH: – –

GENDER: MALE ☐ FEMALE ☐

Prescriber Information

LAST NAME:

FIRST NAME:

PLEASE SELECT ONE: ☐ MD ☐ PA ☐ NP ☐ DO ☐ DDS ☐ OTHER:

NPI NUMBER:

SPECIALTY:

DEA X #: -

DEA X # EXP: – –

PHONE NUMBER: – –

FAX NUMBER: – –

Person Completing Form

LAST NAME:

FIRST NAME:

TITLE:

PHONE NUMBER: – –

FAX NUMBER: – –

DATE:

REQUESTED START DATE:

Pharmacy

NAME:

PHONE NUMBER: – –

FAX NUMBER: – –

Drug Name	Strength	Dosing	Duration of Rx
XENICAL®	120mg		

RESULTS OF A MEDICAL HISTORY AND PHYSICAL EXAM AS WELL AS NUTRITIONAL OR DIETETIC ASSESSMENT. MARK AS 'N/A' IF NO INFORMATION IS AVAILABLE AND CANNOT BE PROVIDED.

HAS THE BENEFICIARY SEEN ANY OTHER PROVIDER FOR THIS CONDITION? ☐ Yes ☐ No If "Yes", what was the provider's specialty and findings?

OTHER DIAGNOSES AND LIST OF CURRENT MEDICATIONS (MARK AS 'N/A' IF NO INFORMATION IS AVAILABLE AND CANNOT BE PROVIDED)

CURRENT BODY MASS INDEX (BMI):

HEIGHT:

CURRENT WEIGHT:

Submit requests to:

Magellan Medicaid Administration
11013 W Broad Street Suite 500, Glen Allen, VA 23060
Fax: 888-603-7696 Phone: 877-864-9014
This form is available at https://michigan.magellanrx.com/provider/forms

© 2016-2019, Magellan Health, Inc. All rights reserved.

Revision Date:12/2019

ARE THERE ANY CONTRAINDICATIONS FOR THIS USE, MALABSORPTION SYNDROMES, CHOLESTASIS, PREGNANCY, AND/OR LACTATION? MARK AS 'N/A' IF NO INFORMATION IS AVAILABLE AND CANNOT BE PROVIDED.

IS THIS PART OF A TOTAL TREATMENT PLAN INCLUDING A CALORIE AND FAT RESTRICTED DIET AND EXERCISE REGIMEN?	☐ Yes ☐ No	If "Yes," please attach copy of plan.
HAVE THERE BEEN AT LEAST 2 PRIOR WEIGHT LOSS PLANS OR PROGRAMS INCLUDING DIET AND EXERCISE REGIMENS?	☐ Yes ☐ No	If "Yes," please attach copies and reason(s) for failures.

ADDITIONAL COMMENTS:

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (Via return FAX) immediately and arrange for the return or destruction of these documents. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.

© 2016-2019, Magellan Health, Inc. All rights reserved.