Print Reset

Michigan Department of Health and Human Services

Prescription Drug Prior Authorization Form

Anti-Obesity Medications

Fax this form to **888-603-7696** A fax cover sheet is not required.

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

Beneficiary's Last Name: _____

Beneficiary's First Name: _____

Medicaid ID: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female

PRESCRIBER INFORMATION

Prescriber's Last Name: _____

Prescriber's First Name: _____

Prescriber Credentials (Select One): ☐ MD ☐ PA ☐ NP ☐ DO ☐ Other: _____

Specialty: _____

Prescriber's NPI: _____

DEA: _____ DEA Expiration: _____

Prescriber's Phone: _____ Prescriber's Fax: _____

PERSON COMPLETING FORM

Person Last Name: _____

Person First Name: _____

Person Title: _____

Person Phone: _____ Person Fax: _____

Form Completion Date: _____ Requested Start Date: _____

PHARMACY INFORMATION

Pharmacy's Name: _____

Pharmacy's Phone: _____ Pharmacy's Fax: _____

Member's Name (Last, First): _____

DRUG INFORMATION

Drug Name: _____

Drug Strength: _____ Dosing Frequency: _____

Duration of Treatment: _____

CLINICAL INFORMATION

Current Body Mass Index (BMI): _____

Height: _____ Current Weight: _____

1. Is the patient age ≥ 18 years and has an initial body mass index (BMI) ≥ 30 kg/m^2?
   ☐ Yes ☐ No
2. Is the patient age ≥ 18 years and has an initial body mass index (BMI) ≥ 27 kg/m^2 but < 30 kg/m^2 and at least one of the following risk factors: hypertension, coronary artery disease, diabetes, dyslipidemia, sleep apnea?
   ☐ Yes ☐ No
3. Does the patient age ≥ 12 years to < 18 years have an initial BMI per CDC growth charts at the 95th percentile or greater for age and sex (obesity)?
   ☐ Yes ☐ No
4. Does the patient age ≥ 12 years to < 18 years have an initial BMI in the 85th to 94th percentile (overweight) per CDC growth charts and at least one of the following weight-related coexisting conditions: hypertension, diabetes, dyslipidemia, sleep apnea?
   ☐ Yes ☐ No
5. Minimum age attestation:
   a. For Wegovy®, Xenical®, or Saxenda®: Is the patient 12 years of age or older?
      ☐ Yes ☐ No
   b. For benzphetamine, diethylpropion, phentermine, or phendimetrazine: Is the patient 18 years of age or older?
      ☐ Yes ☐ No
6. For patients with an eating disorder, has treatment been optimized and safety and appropriateness confirmed?
   ☐ Yes ☐ No
7. Have metabolic or other reasons for obesity been ruled out or diagnosed and treated (e.g., thyroid dysfunction, diabetes, sleep apnea)?
   ☐ Yes ☐ No

Member's Name (Last, First): _____

8. Does the patient have any contraindications to the use of this medication such as pregnancy, lactation, personal, or family history of medullary thyroid cancer or multiple endocrine neoplasia type II?
   ☐ Yes ☐ No
9. Will the medication therapy be a part of a total treatment plan including a calorie and fat-restricted diet and exercise regimen?
   ☐ Yes ☐ No
10. Has the patient been informed that weight may return with cessation of medication unless healthy lifestyle diet and activity changes, as appropriate for the patient's ability, are permanently adopted.
    ☐ Yes ☐ No

MDHHS recommends that prescribers consider the benefits of a diabetes prevention program for their patients.

Renewal Requests for Continuation of Therapy:

1. For patients age ≥ 18 years, has clinical documentation been provided showing that the patient has maintained a weight loss of ≥ 5% of weight at time of last prior authorization?
   ☐ Yes ☐ No

   Baseline weight: _____ Current weight: _____
2. For patients age ≥ 12 years to < 18 years, has clinical documentation been provided showing that the patient maintained or improved BMI per CDC growth charts from baseline weight at initiation of therapy?
   ☐ Yes ☐ No

   Baseline BMI percentile: _____ Current BMI percentile: _____

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group, or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber's Signature: _____ **Date:** _____

(By signature, the physician confirms the above information is accurate and verifiable by patient records.)

Member's Name (Last, First): _____

Mail requests to:
Magellan Medicaid Administration
11013 W Broad Street
Suite 500
Glen Allen, VA 23060

Phone: (877) 864-9014
Fax: (888) 603-7696

This form is available at https://michigan.magellanrx.com/provider/forms

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