

OBESITY TREATMENT AGENTS PRIOR AUTHORIZATION FORM (form effective 1/8/2024)

Prior authorization guidelines for **Obesity Treatment Agents** and **Quantity Limits/Daily Dose Limits** are available on Geisinger Health Plan's website at <https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger>

<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:	
Additional strengths / quantity for each / refills for each to allow for <u>dose titration</u> :	
Directions:	
Diagnosis (<i>submit documentation</i>):	Dx code (<i>required</i>):
For a non-preferred Obesity Treatment Agent , does the beneficiary have a history of trial and failure of or a contraindication or an intolerance to the preferred Obesity Treatment 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>
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 weight-related comorbidities:

☐ dyslipidemia

☐ obstructive sleep apnea

☐ hypertension

☐ prediabetes

☐ metabolic syndrome

☐ type 2 diabetes

☐ 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 has at least one of the following weight-related comorbidities:

☐ dyslipidemia

☐ obstructive sleep apnea

☐ hypertension

☐ prediabetes

☐ metabolic syndrome

☐ type 2 diabetes

☐ 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

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

☐ 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 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 submit to PromptPA <https://ghp.promptpa.com> OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:

Date:

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