

OBESITY TREATMENT AGENTS PRIOR AUTHORIZATION FORM (form effective 1/9/2023)

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:
Directions:		
Diagnosis (<i>submit documentation</i>):		Dx code (<i>required</i>):
For a non-preferred Anti-Obesity Agent , does the beneficiary have a history of trial and failure of or a contraindication or an intolerance to the preferred Anti-Obesity 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 <i>Submit documentation.</i> <input type="checkbox"/> No
For a controlled substance Obesity Treatment Agent (e.g., phentermine, Qsymia, etc.) , did the prescriber or prescriber's delegate search the PDMP to review the beneficiary's controlled substance prescription history before issuing this prescription for the requested agent?		<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No
Does the beneficiary have any contraindications to the requested medication?		<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No
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 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 at least one of the following 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
- Has a BMI in the 85th percentile or greater standardized for age and sex based on current CDC charts and at least one of the following comorbidities:
 - dyslipidemia
 - obstructive sleep apnea
 - hypertension
 - prediabetes
 - metabolic syndrome
 - type 2 diabetes
 - other (list): _____

- Is a candidate for treatment based on degree of adiposity, previous bariatric surgery, etc. and at least one of the following comorbidities:
 - dyslipidemia
 - obstructive sleep apnea
 - hypertension
 - prediabetes
 - metabolic syndrome
 - type 2 diabetes
 - other (list): _____

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

- The beneficiary 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 and/or a positive response to treatment 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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