



**PRIOR AUTHORIZATION FORM
Weight Loss**

DATE OF REQUEST: _____

MEMBER INFORMATION

NAME _____

ID # _____

BIRTHDATE _____

PLEASE NOTE: By signing this form, you are attesting to the accuracy of the information provided, and that medical record documentation is available if requested.

PROVIDER INFORMATION

NAME _____

NPI # _____

ADDRESS _____

PHONE # _____ FAX # _____

CONTACT NAME _____

PROVIDER SIGNATURE _____

Drug Requested (one drug per member per treatment period) _____ **Strength** _____ **Dose** _____

Diagnosis: _____ **ICD-9** _____

Treatment period (minimum 4 lb. loss required in 1st month and then 10 lb. loss in the 3 months immediately preceding the request)

<input type="checkbox"/> 1st Month (Initial)	<input type="checkbox"/> Months 2 & 3	<input type="checkbox"/> Months 4 – 6	<input type="checkbox"/> Months 7 – 9	<input type="checkbox"/> Months 10 - 12
Height _____				
Weight _____ lbs.	Weight _____ lbs.	Weight _____ lbs.	Weight _____ lbs.	Weight _____ lbs.
Date _____	Date _____	Date _____	Date _____	Date _____
Reduced calorie diet and appropriate exercise program must be maintained for 6 months prior to request.				
<input type="checkbox"/> Diet maintained	<input type="checkbox"/> Diet maintained	<input type="checkbox"/> Diet maintained	<input type="checkbox"/> Diet maintained	<input type="checkbox"/> Diet maintained
<input type="checkbox"/> Regular exercise	<input type="checkbox"/> Regular exercise	<input type="checkbox"/> Regular exercise	<input type="checkbox"/> Regular exercise	<input type="checkbox"/> Regular exercise
Document BP, HDL/LDL, HbA1c and date for comorbidities listed below if applicable to this member.				
<input type="checkbox"/> Hypertension				
BP _____	BP _____	BP _____	BP _____	BP _____
Date _____	Date _____	Date _____	Date _____	Date _____
<input type="checkbox"/> Hyperlipidemia				
HDL/LDL _____				HDL/LDL _____
Date _____				Date _____
<input type="checkbox"/> Diabetes				
HbA1c _____		HbA1c _____	HbA1c _____	HbA1c _____
Date _____		Date _____	Date _____	Date _____

FAX THIS REQUEST TO:
 Commercial **1-800-376-6373**
 (HMO, EPO/PPO, Option Child, Healthy NY, Personal Plan, CompCare, ASO)

Medicare Part D **1-800-401-0915**
 (Preferred Gold, GoldAnywhere, GoldValue, USA Care, MVP RxCare)

Effective July 2011