OBESITY TREATMENT AGENTS PRIOR AUTHORIZATION FORM





(form effective 1/6/2025)

Fax to PerformRx $^{\text{SM}}$ at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774**.

PRIOR AUTHORIZATION REQUEST						
□ New request □ Renewal request	Total # of pgs:	Prescriber name:				
Name of office contact:		Specialty:				
Contact's phone number:		NPI:	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 eac	h to allow for dose titration:					
Directions:						
Diagnosis (submit documentation):			DX code (required)	,		
			□ Yes			
Does the beneficiary have any contraindications to	the requested medication?		□ No	Submit documentation.		
ATTESTATION from the prescriber: Was beneficiar behavior modifications such as a healthy diet and in		estyle changes and	☐ Yes ☐ No			
Con	nplete all sections that an	poly to the beneficiary a	and this request.			
Complete all sections that apply to the beneficiary and this request. Check all that apply and submit documentation for each item.						
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INITIAL REQUESTS 1. The beneficiary is 18 years of age or older an Pre-treatment weight: □ Has a BMI greater than or equal to 30 kg/m □ Has a BMI greater than or equal 27 kg/m2	nd: Pre-treatment BMI: n2 and less than 30 kg/m2 AND a	it least one of the following		rbidities:		
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(Refe	est is for a <u>PREFERRED Obesity Treatment Agent containing a GLP-1 RECEPTOR AGONIST</u> (e.g., Saxenda, Wegovy, Zepbound) r to <u>https://papdl.com/preferred-drug-list</u> for a list of preferred and non-preferred drugs in this class.): I Has a concurrent diagnosis of diabetes mellitus OR has taken an antidiabetic drug in the last 120 days and:
(Refe	r to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.): Has a concurrent diagnosis of diabetes mellitus OR has taken an antidiabetic drug in the last 120 days and:
	o ,
	☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a
	GLP-1 receptor agonist:
	☐ Ozempic ☐ Trulicity
	□ Victoza
	Does NOT have diabetes mellitus and has NOT taken an antidiabetic drug in the past 120 days
5 Rom	est is for a NON-PREFERRED Obesity Treatment Agent containing a GLP-1 RECEPTOR AGONIST (Refer to https://papdl.com/preferred-drug-list
	list of preferred and non-preferred drugs in this class.):
	IHas a history of trial and failure of or a contraindication or an intolerance to the preferred Obesity Treatment Agents containing a GLP-1 receptor agonist that are medically
	accepted for the beneficiary's diagnosis:
	□ Saxenda
	☐ Wegovy ☐ Zepbound
Г	Has a history of trial and failure of or a contraindication or an intolerance to the preferred Hypoglycemics, Incretin Mimetics/Enhancers containing a
	GLP-1 receptor agonist that are medically accepted for the beneficiary's diagnosis:
	□ Ozempic
	□ Trulicity
	□ Victoza
-	est is for <u>ANY OTHER NON-PREFERRED Obesity Treatment Agent</u> (i.e., NOT Evekeo [amphetamine] or a drug containing a GLP-1 receptor agonist)
•	r to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.):
L	Has a history of trial and failure of or a contraindication or an intolerance to the preferred Obesity Treatment Agents approved or medically
	accepted for the beneficiary's diagnosis or indication: □ phentermine capsule or tablet □ Wegovy
RENE	□ Saxenda □ Zepbound
	□ Saxenda □ Zepbound WAL REQUESTS
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1. For a P 2. For a P P 3. All re	WAL REQUESTS beneficiary 18 years of age or older: e-treatment weight:
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1. For a P 2. For a P P 3. All re 4. Requ for a	WAL REQUESTS beneficiary 18 years of age or older: e-treatment weight: beneficiary less than 18 years of age: e-treatment BMI: c-treatment BM
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RENEWAL REQUESTS (continued)						
6. Request is for <u>ANY OTHER NON-PREFERRED Obesity Treatment</u> Agent (i.e., NOT Evekeo [amphetamine] or a drug containing a GLP-1 receptor agonist)						
(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.): \[\sum Has a history of trial and failure of or a contraindication or an intolerance to the preferred Obesity Treatment Agents approved or medically accepted for the beneficiary's diagnosis or indication:						
phentermine capsule or tablet	□ Wegovy					
☐ Saxenda	□ Zepbound					
PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION						
Prescriber signature:		Date:				

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