**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division Medicaid Services Wis. Admin. Code § DHS 107.10(2)

F-00163 (04/2023)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION DRUG ATTACHMENT FOR ANTI-OBESITY DRUGS**

**INSTRUCTIONS:** Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Anti-Obesity Drugs Instructions, F-00163A. Prescribers may refer to the Forms page of the ForwardHealth Portal at <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms> for the completion instructions.

Prescribers and pharmacy providers may call the Drug Authorization and Policy Override Center at 800-947-9627 with questions.

|  |
| --- |
| **SECTION I – MEMBER INFORMATION** |
| 1. Name – Member (Last, First, Middle Initial)      |
| 2. Member ID Number      | 3. Date of Birth – Member      |
| **SECTION II – PROVIDER INFORMATION** |
| 4. Name – Prescriber      |
| 5. Address – Prescriber (Street, City, State, Zip+4 Code)      |
| 6. Phone Number – Prescriber      | 7. National Provider Identifier (NPI) – Prescriber      |
| 8. Name – Billing Provider      |
| 9. NPI – Billing Provider      |
| **SECTION III – PRESCRIPTION INFORMATION** |
| 10. Drug Name      | 11. Drug Strength      |
| 12. Date Prescription Written      | 13. Refills      |
| 14. Directions for Use      |
| **SECTION IV – CLINICAL INFORMATION** |
| 15. Diagnosis Code and Description      |
| 16. Height – Member (Inches)      | 17. Weight – Member (Pounds)      |

|  |  |
| --- | --- |
| 18. Date Member’s Weight Was Measured      | 19. Body Mass Index (BMI) – Member (lb / in2)      |
| 20. Goal Weight – Member (Pounds)      | BMI = 703 X (weight in pounds) (height in inches)2 |
| For an initial prior authorization (PA) request, the prescriber must complete Sections IV A and IV B. For a renewal PA request, the prescriber must complete Section IV A. |
| **SECTION IV A – INITIAL AND RENEWAL COVERAGE REQUIREMENTS** |
| 21. Enter the member’s age.      **Note: Members must be 18 years of age or older for approval of PA requests for anti-obesity drugs, except for Evekeo, Saxenda, Wegovy, and Xenical. Members must be 12 years of age or older to take Evekeo, Saxenda, Wegovy, and Xenical.** |
| 22. Is the member pregnant or nursing? [ ]  Yes [ ]  No |
| 23. Does the member have a history of an eating disorder (for example, anorexia, bulimia, or binge eating disorder)? [ ]  Yes [ ]  No |
| 24. Has the prescriber evaluated the member and determined that they do not have any medicalor medication contraindications to treatment with the anti-obesity drug being requested? [ ]  Yes [ ]  No |
| 25. Does the member have a medical history of substance abuse or misuse? [ ]  Yes [ ]  No |
| **SECTION IV B – INITIAL COVERAGE REQUIREMENTS** |
| 26. BMI Requirements (Check A, B, C, or D.)A. [ ]  The member is 18 years of age or older (or 12 years of age or older for Evekeo requests only) and has a BMI greater than or equal to 30.B. [ ]  The member is 18 years of age or older (or 12 years of age or older for Evekeo requests only) **and** has a BMI greater than or equal to 27 but less than 30 **and** has two or more of the following risk factors. Check the member’s current risk factors:[ ]  Coronary Heart Disease[ ]  Dyslipidemia[ ]  Hypertension[ ]  Sleep Apnea[ ]  Type 2 Diabetes MellitusC. [ ]  Saxenda PA requests for members 12–17 years of age: The member has a body weight above 132 pounds and a BMI corresponding to 30 or greater for adults by international cut-offs. D. [ ]  Wegovy and Xenical PA requests for members 12–17 years of age: The member has a BMI greater than or equal to the 95th percentile standardized by age and sex. |
| 27. Has the member participated in a weight loss treatment plan (for example, nutritional counseling, an exercise regimen, or a calorie-restricted diet) in the past six months, and will the member continue to follow this treatment plan while taking an anti-obesity drug? [ ]  Yes [ ]  NoIf yes, describe the treatment plan in the space provided.      |
| **SECTION V – AUTHORIZED SIGNATURE** |
| 28. **SIGNATURE** – Prescriber | 29. Date Signed – Prescriber |
| **SECTION VI – ADDITIONAL INFORMATION** |
| 30. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.      |