**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.

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| **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) |

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| 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 medical or 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 Mellitus  C.  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  No  If 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. | | |