

**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 / in ²)
20. Goal Weight – Member (Pounds)	$\text{BMI} = \frac{703 \times (\text{weight in pounds})}{(\text{height in inches})^2}$

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.
