Print Reset

Michigan Department of Health and Human Services
Prescription Drug Prior Authorization Form
Anti-Obesity Medications/Non-GLP1 Medications

Fax this form to **888-603-7696** A fax cover sheet is not required.

All information on this form must be addressed. Incomplete forms will be returned only once for missing information. Mark as "N/A" if no information is available or does not apply. Issues that remain blank after being returned once will receive a denial and will not qualify for MDHHS physician review until completed or clearly marked "N/A."

BENEFICIARY INFORMATION

Beneficiary's Last Name: _____

Beneficiary's First Name: _____

Medicaid ID: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female

PRESCRIBER INFORMATION

Prescriber's Last Name: _____

Prescriber's First Name: _____

Prescriber Credentials (Select One): ☐ MD ☐ PA ☐ NP ☐ DO ☐ Other: _____

Specialty: _____

Prescriber's NPI: _____

DEA: _____ DEA Expiration: _____

Prescriber's Phone: _____ Prescriber's Fax: _____

PERSON COMPLETING FORM

Person Last Name: _____

Person First Name: _____

Person Title: _____

Person Phone: _____ Person Fax: _____

Form Completion Date: _____ Requested Start Date: _____

PHARMACY INFORMATION

Pharmacy's Name: _____

Pharmacy's Phone: _____ Pharmacy's Fax: _____

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Member's Name (Last, First): _____

DRUG INFORMATION

Drug Name: _____

Drug Strength: _____ Dosing Frequency: _____

Duration of Treatment: _____

CLINICAL INFORMATION

Current Body Mass Index (BMI): _____

Height: _____ Current Weight: _____

1. Prescriber attests that the patient will not use more than one weight loss medication in this drug class concurrently.
   ☐ Yes ☐ No
2. Is the patient age ≥ 18 years and has an initial body mass index (BMI) ≥ 30 kg/m^2?
   ☐ Yes ☐ No
3. Is the patient age ≥ 18 years and has an initial body mass index (BMI) ≥ 27 kg/m^2 but < 30 kg/m^2 and at least one of the following risk factors: hypertension, coronary artery disease, diabetes, dyslipidemia, sleep apnea?
   ☐ Yes ☐ No
4. Does the patient age ≥ 12 years to < 18 years have an initial BMI per CDC growth charts at the 95th percentile or greater for age and sex (obesity)?
   ☐ Yes ☐ No
5. Does the patient age ≥ 12 years to < 18 years have an initial BMI in the 85th to 94th percentile (overweight) per CDC growth charts and at least one of the following weight-related coexisting conditions: hypertension, diabetes, dyslipidemia, sleep apnea?
   ☐ Yes ☐ No
6. Minimum age attestation:
   a. For Xenical or phentermine/topiramate: Is the patient 12 years of age or older?
      ☐ Yes ☐ No
   b. For phentermine: Is the patient 17 years of age or older?
      ☐ Yes ☐ No
   c. For benzphetamine, diethylpropion, or phendimetrazine: Is the patient 18 years of age or older?
      ☐ Yes ☐ No
7. For patients with an eating disorder, has treatment been optimized and safety and appropriateness confirmed?
   ☐ Yes ☐ No

Member's Name (Last, First): _____

8. Have metabolic or other reasons for obesity been ruled out or diagnosed and treated (e.g., thyroid dysfunction, diabetes, sleep apnea)?
   ☐ Yes ☐ No
9. Does the patient have any contraindications to the use of this medication such as pregnancy, lactation, personal, or family history of medullary thyroid cancer or multiple endocrine neoplasia type II?
   ☐ Yes ☐ No
10. Will the medication therapy be a part of a total treatment plan including a calorie and fat-restricted diet and exercise regimen?
    ☐ Yes ☐ No
11. Has the patient been informed that weight may return with cessation of medication unless healthy lifestyle diet and activity changes, as appropriate for the patient's ability, are permanently adopted.
    ☐ Yes ☐ No

MDHHS recommends that prescribers consider the benefits of a diabetes prevention program for their patients.

Renewal Requests for Continuation of Therapy:

1. For patients age ≥ 18 years, has clinical documentation been provided showing that the patient has maintained a weight loss of ≥ 5% of weight at time of last prior authorization?
   ☐ Yes ☐ No

   Baseline weight: _____ Current weight: _____
2. For patients age ≥ 12 years to < 18 years, has clinical documentation been provided showing that the patient maintained or improved BMI per CDC growth charts from baseline weight at initiation of therapy?
   ☐ Yes ☐ No

   Baseline BMI percentile: _____ Current BMI percentile: _____

☐ Attachments

Member's Name (Last, First): _____

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group, or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber's Signature: _____ **Date:** _____

(By signature, the physician confirms the above information is accurate and verifiable by patient records.)

Mail requests to:

Prime Therapeutics State Government Solutions LLC
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Phone: 877-864-9014

Fax: 888-603-7696

This form is available at https://mi.primetherapeutics.com/provider/forms/.

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