AmeriHealth Caritas New Hampshire

Anti-Obesity Medications

Prior Authorization Drug Approval Form

Date of medication request: (MM/DD/YYYY): ____ / ____ / _____

Patient information and medication requested	
Patient's name:	Medicaid number:
Date of birth:	Gender:
Drug name:	Strength:
Dosing directions:	Length of therapy:

Prescriber information		
Prescriber name:		NPI number:
Prescriber address:		Prescriber representative:
Phone #:	Fax #:	

Clinical history			
1. Patient's diagnosis:			
2. Has the patient failed to lose weight on a low calorie diet (1,200 kcal/day women, 1,600 kcal/day men) and exercise regimen after at least a 3-month trial? ☐ Yes ☐ No Please explain:			
3. Does the patient have BMI > 30 kg/m2 with no risk factors, or > 27 kg/m2 with at least one (1) high risk factor, or two (2) other risk factors? ☐ Yes ☐ No			
4. Patient's BMI:	Weight:	Height:	Date:
5. Waist circumference:			
6. Does the patient have any of the following high risk factors? ☐ Sleep apnea ☐ Coronary heart disease ☐ Type 2 diabetes ☐ Atherosclerotic disease			
7. Does the patient have any of the following risk factors? ☐ Hypertension ☐ Gallstones ☐ Family history of premature heart disease ☐ Impaired fasting glucose concentration ☐ Dyslipidemia ☐ Stress incontinence ☐ Cigarette smoking ☐ Gynecologic abnormalities ☐ Osteoarthritis ☐ Age (men > 45 years, women > 55 years or postmenopausal)			
8. Are there any contraindications to the use of this drug for this patient? ☐ Yes ☐ No If yes, please explain:			
Provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.			

Signature of prescriber:_____ Date: _____
(prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.