Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Antiobesity Agents Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 6 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Antiobesity Agents.** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: http://pithelp.appl.kp.org/MAS/formulary.html**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Provider Name: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Please check the boxes that apply:

□Initial Request □ Continuation of Therapy Request

□ Standard Review (72 hours)

□ Expedited Review (24 hours): By checking this box, I certify that applying 72 hours standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Provider Signature_____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5 – Diagnosis

Body Mass Index (BMI) Requirements:

□ BMI ≥ 30 OR □ BMI ≥ 27, with ≥ 2 of the following risk factors (select below)

□ Coronary Heart Disease
□ Dyslipidemia
□ Hypertension
□ Sleep Apnea
□ Type 2 Diabetes

6 – Clinical Criteria

Initial Therapy:

Is the patient ≥ 16 years old? (Exception: If requesting Saxenda, is the patient ≥ 18 years old?)
□ No □ Yes

Does the patient does not have any of the following contraindications?
□ Malabsorption Syndromes □ Cholestasis □ Pregnant and/or Breastfeeding □ History of Eating Disorders

Current Height: _____ Current Weight: _____

Please provide documentation of the patient's current medical status, including:
□ Nutritional or Dietetic Assessment

_____

_____

□ Current Weight Loss Plan or Program with Diet and Exercise Components

_____

_____

_____

_____

Continuation of Therapy:

□ Continue to meet Initial Therapy criteria
□ BMI ≥ 24
□ Documentation of continued weight loss while on requested therapy

7 – Provider Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration.

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**