



# Virginia Medicaid ANTI-OBESITY DRUGS Prior Authorization Request Form

Virginia Medicaid has coverage limits and criteria for prior authorization of weight loss medications. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for these drugs, it will be necessary for the prescriber to complete and fax or mail this prior authorization request to First Health Services Corp. at the address listed at the bottom of this form. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

**Use this form for Anti-Obesity drug prior authorization requests only.**

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## Prescribing physician:

Name/NPI#: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

## Beneficiary:

Name: \_\_\_\_\_

Recipient ID #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

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Pharmacy (if known): \_\_\_\_\_ Phone: \_\_\_\_\_ &/or FAX: \_\_\_\_\_

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Drug Requested: \_\_\_\_\_ Strength & Frequency: \_\_\_\_\_ Length of therapy: \_\_\_\_\_

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### Coverage for these medications will be limited to the following:

#### 1. BMI requirements:

- Body mass index [BMI]: > than 40, if no other diagnoses
- Body mass index [BMI]: > than 35, if diagnosis of hypertension, coronary artery disease, CHF, diabetes, dyslipidemia, sleep apnea, or other comorbidity

#### 2. Age restrictions:

- Covered only for those over 18 years old. Reconsideration or appeal **for children younger than age 18 years** should be directed to the DMAS Director of Medical Support and will be accepted only with referral from a pediatrician or a primary care specialist.

Note: Patient must be eligible for coverage at the point of sale (determined by supplying pharmacy).

#### 3. Documentation Accepted From: a licensed physician [Prescriber] and must be written or faxed.

#### 4. The written documentation must include:

- Current medical status including nutritional or dietetic assessment.
- Current therapy for all medical condition[s] including obesity, indentifying specific treatments including medications.
- Current accurate height and weight measurements.
- No medical contraindications to use a reversible lipase inhibitor (Xenical).
- Current weight loss plan or program including diet and exercise plan.

#### 5. If the physician does not have the necessary information, the request will be denied and the fax form requesting additional information will be sent to the prescriber.

#### 6. Initial Request Requirements:

- No contraindications to use
- No malabsorption syndromes, cholestasis, pregnancy and/or lactation.
- Part of a total treatment plan including a calorie and fat restricted diet and exercise regimen.
- For Meridia: caution should be used if the following therapies are present:
  - MAOI
  - Drugs for migraine therapy
  - Serotonin Inhibitors
  - Antihistamines / Decongestants
  - Or if the following conditions are present
    - Hypertension
    - Pregnant Or Nursing
    - Anorexia Nervosa

7. **Length of Authorization**

- Initial request: 3-month approval.
- Renewal: up to 6 months if the patient has met the goal of > or = 12lbs of weight loss, if less than 12lbs the 3 month renewals.  
Continued approval is contingent on patient maintaining weight loss
- Dispense Limit: 30 Day Supply

8. **Assessment:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

9. **Other Diagnosis:** \_\_\_\_\_

10. **Current medications:** \_\_\_\_\_

11. Current body mass index (BMI): \_\_\_\_\_ Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_

12. Are there any contraindications for this use, malabsorption syndromes, cholestasis, pregnancy and/or lactation?

**YES**      **NO**      If YES, please describe:

13. Is this part of a total treatment plan including a calorie and fat restricted diet and exercise regimen?

**YES**      **NO**      If YES, please attach copy of plan.

14. Have there been any previous weight loss plans or programs including diet and exercise plans?

**YES**      **NO**      If YES, please attach copy of plan and reason for failure.

Comments:

**Prescriber Signature:** \_\_\_\_\_ **Date of this request:** \_\_\_\_\_

FOR FIRST HEALTH USE				
Approved	Changed	Denied	Pending	Comments:
MAP RPh/tech:	_____	_____	_____	_____
NDC:	_____	_____	_____	_____
Date of Decisions:	_____	_____	_____	_____

Submit requests via phone, fax or mail to:

**First Health Services Corp.**  
**MAP Dept.**  
**4300 Cox Road**  
**Glen Allen, VA 2306**

**Tel: 1-800-932-6648**

**FAX: 1-800-932-6651**

DMAS-172

REV:3/07

