

# Prior Authorization Form

NOTE: Refer to the Provider Manual for additional services requiring **Prior Authorization**



Fax Form To: **Grand Rapids – 616 942-0024** **Holland – 616 392-7626** **ASO – 616 395-4090** **Traverse City – 231 932-9505**

## Medical Weight Loss Program

### Member

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

ID #: \_\_\_\_\_ DOB: \_\_\_\_\_ (Must be 16 years of age or older.)

Plan/Product Type:  EPO  HMO  POS  SF-POS  PPO  Medicaid  Medicare

Primary Care Physician: \_\_\_\_\_ PCP Phone: \_\_\_\_\_ PCP Fax: \_\_\_\_\_

Has PCP been notified of request?  Yes  No Contact Name: \_\_\_\_\_

Initial Request

Retreatment Request Start Date of Last Program: \_\_\_\_\_

### Directed To:

**Treatment must be provided by a weight management program approved under Priority Health's Center of Excellence Policy.**

Program Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ Contact Name: \_\_\_\_\_

### Clinical Condition

Current Weight: \_\_\_\_\_ Current Height: \_\_\_\_\_ BMI: \_\_\_\_\_ Date weight and height measured: \_\_\_\_\_

Check criteria that applies:  BMI  $\geq$  35 and two obesity-related co-morbidities **OR**

BMI  $\geq$  40 and one obesity-related co-morbidity **OR**

BMI  $\geq$  45 (co-morbidities not needed)

### Obesity-related co-morbidities (check all that apply)

Symptomatic sleep apnea (A/H Index > 10). A/H Index = \_\_\_\_\_

Significant cardiac disease (ASHD, LVH or RVH)  
Diagnosis \_\_\_\_\_

Hypertension  
Is medication treatment required? Y N

Hyperlipidemia (>30mg/dl above goal) HDL/LDL \_\_\_\_\_  
Is medication treatment required? Y N

Diabetes (HgbA1C>7.0). HgbA1C \_\_\_\_\_  
Is medication treatment required? Y N

GERD (persistent symptoms despite daily medications). Do symptoms persist? Y N  
Is medication treatment required? Y N

Degenerative joint disease markedly limiting daily activities.

Non-alcoholic steatohepatitis (NASH)

Depression requiring medication and psychological counseling

No co-morbidities present.

**\*\*\*ALL FIELDS MUST BE COMPLETE AND LEGIBLE FOR PRIOR AUTHORIZATION REVIEW\*\*\***

### For Priority Health Use Only:

BMI verified by: \_\_\_\_\_ CSM Notification Complete

\_\_\_\_\_ Date: \_\_\_\_\_

Date: \_\_\_\_\_