

Prior Authorization Form

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

Fax Form To: 616 942-0024

Bariatric Surgery Evaluation

Member

Last Name: _____ First Name: _____
ID #: _____ DOB: _____ (Must be 18 years of age or older.)
Primary Care Physician: _____ PCP Phone: _____ PCP Fax: _____
Has PCP been notified of request? Yes No Contact Name: _____

Required

Medical obesity treatment may be provided by a credentialed physician with a declared interest in the medical treatment of obesity, the member's primary care physician (PCP) or other managing physician. Please refer to the *Medical Management of Obesity policy #91594* for specific criteria and documentation requirements which must be included (if applicable) when submitting this form.

Medical Management Program Supervised By (if required): _____

Dates of Attendance: _____

Directed To

Roux-en-Y gastrojejunostomy, laparoscopically adjustable banding (Lap-Band and Biliopancreatic Diversion with Duodenal Switch (BPD/DS) and sleeve gastrectomy are the only bariatric procedures that will be authorized. **Coverage is limited to one bariatric surgery per lifetime regardless of insurance carrier at the time of surgery, unless medically/clinically necessary to correct or reverse complications from a previous bariatric procedure.** The surgery must be performed by a surgeon who is a regular member of the American Society for Metabolic & Bariatric Surgery (ASMBS).

Surgeon Name: _____ Address: _____
Phone: _____ Fax: _____ Contact Name: _____

Clinical Condition

Current Weight: _____ Current Height: _____ *BMI: _____ Date weight and height measured _____

* BMI should be based upon measurement of height and weight within one month of requesting the evaluation.

- Check criteria that applies: BMI \geq 35, participation in medical weight management program, and at least **one** of the obesity-related co-morbidities listed below.
- BMI \geq 40, participation in medical weight management program
- BMI \geq 50

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

- Symptomatic sleep apnea requiring treatment Treatment: CPAP BI PAP Oral Appliance
(C@& One)
- Significant cardiac disease/pulmonary disease (ASHD, RVH, LVH)
Diagnosis _____
- Hypertension on one or more medications. Average B/P _____
Meds/Dose _____
- Hyperlipidemia on therapy
HDL/LDL _____ Onset Date _____
Meds/Dose _____
- Diabetes with HgbA1C > 7.0 requiring on one or more medications.
HgbA1C _____ Onset Date _____
Orals Meds/Dose _____
Insulin Therapy _____
- No co-morbidities present