Prior Authorization Form

Fax form to: 888.647.6152

Bariatric Surgery

PriorityHealth
THINK SMART. LIVE SMART.

Clear Form

Member

Last name:_____ First name: _____

Contract #:_____ DOB:_____(Must be 18 years of age or older.)

Primary care physician: _____ Phone:_____ Fax: _____

Has PCP been notified of request? ☐ Yes ☐ No Hospital: _____

*Surgeon_____Phone:_____Fax:_____

Address:_____Surgery Date (if known):_____

Contact Name:_____Phone:_____Fax: _____

*Is the surgeon who will be performing the surgery a regular member of the American Society for Metabolic & Bariatric Surgery (ASMBS)? ☐ Yes ☐ No

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: _____

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 surgery.

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

☐ BMI ≥ 40, participation in medical weight management program

☐ BMI ≥ 50

Obesity-related co-morbidities (check all that apply and complete required information)

☐ Symptomatic sleep apnea requiring treatment Treatment (Check One): ☐ CPAP ☐ BI PAP ☐ Oral Appliance

☐ 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 one or more medications or insulin. HgbA1C_____Onset Date_____
Orals Meds/Dose_____Insulin Therapy_____

☐ No co-morbidities present

Treatment requested

☐ Primary Bariatric Surgical (PBS) Treatment ☐ Revisional Bariatric Surgical (RBS) Treatment

Please select procedure being requested, including the CPT Code

☐ Ro en Y – **CPT Code** _____
☐ La roscopically Adjustable Banding (with an FDA approved device) – **CPT Code** _____
☐ Bil ancreatic Diversion with Duodenal Switch – **CPT Code** _____
☐ Sl e Gastrectomy (specific criteria must be met) – **CPT Code** _____
☐ Ot – **CPT Code** _____

Required

Need to include the following for medical review

☐ Surgeon Evaluation ☐ Internist Evaluation* ☐ Complete Psychological Evaluation (required for Medicaid members only)
*in some cases surgeon does medical evaluation also

If any of the following medical conditions are present, surgery is contraindicated.

☐ Pregnancy/lactation
☐ S ere psychopathology (based on a professional mental health evaluation)
☐ M ical conditions that make patient a prohibitive risk
☐ A disease (e.g. cancer, uremia, liver failure), associated with a likelihood of survival less than 1 year
☐ S stance abuse including alcohol and other drugs of abuse. Six months of abstinence prior to surgery is required to meet this criterion.
☐ T acco use. *At least one month of abstinence prior to surgery is required to meet this criterion. The surgeon must require at least one month of tc cco abstinence prior to the surgical procedure. **Quit Date:** _____

***Please note surgery will not be approved unless abstinence criterion prior to surgery date is met.**

Print

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