# Prescription Medication Prior Authorization Request Form

☐ Standard PA Request ☐ Urgent/Expedited PA Request

Please fill out all sections and attach any important documentation such as chart notes or lab results to support the PA request..
Once completed, submit to WithMe Health via fax at **1-866-678-8301**

NOTE: NOT ALL PLANS COVER WEIGHT LOSS MEDICATIONS

## Patient Information

| | | |
|---|---|---|
| Patient Name (Last, First, MI): | | |
| Member ID Number: | Date of Birth: | Patient Phone Number: |
| Patient Address: | | |
| Patient's Authorized Representative (If applicable): | | Authorized Rep Phone Number: |

## Provider Information

| | | |
|---|---|---|
| Requesting Provider's Name: | | |
| NPI: | Specialty: | |
| Office Address: | | |
| Office Phone: | Office Fax: | |
| Office Contact Name: | Phone: | Fax: |
| Dispensing Pharmacy Name/Place of Service: | Phone: | Fax: |

## Requested Medication Information

| | |
|---|---|
| Medication Name and Strength: | |
| Dose and Frequency (Sig): | |
| Qty Per 30 Days: | Expected Duration of Therapy: |
| ICD-10(s): | Diagnosis: |

Please check one of the boxes below. If established, please include therapy start date:

☐ New Therapy ☐ Samples ☐ Clinical Trial ☐ Established Date Therapy Started: _____

## Previous Therapies Used for Diagnosis (Rx and OTC products)

| Medication Name, Strength, Dose, Frequency | Dates Used | Outcome of Therapy (e.g. Ineffective, Not Tolerated) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Medical Rationale for Use of Requested Medication (**Please attach chart notes, lab work etc. when submitting this request. If applicable, please include why formulary therapies may be contraindicated for this patient.** Please also include which therapies will be used along with the requested medication. If patient is established on the requested medication, please include recent documentation of how the patient has responded to therapy.):

**Disease State Specific Questions**

**Please provide the following information:**

1. What is the patient's baseline weight?

   _____

2. Are weight management medications being used as part of a comprehensive weight loss plan which includes diet, physical activity, and behavioral therapy? ☐ Yes ☐ No
3. Does the patient have any contraindications or exclusions to use of therapy? ☐ Yes ☐ No
4. Please indicate which of the following apply to the patient:

   Patient has the following documented body mass index (BMI):

   ☐ ≥ 30 kg/m2 (adult)

   ☐> 60Kg (children aged 12-17 years) for Saxenda (liraglutide)

   Patient has a documented BMI ≥ 27 kg/m2 with at least one or more of the following comorbid conditions or risk factors (check all that apply):

   ☐Hypertension

   ☐Dyslipidemia

   ☐Type 2 diabetes

   ☐Patient has none of these risk factors
5. Please provide documentation that lifestyle changes (e.g. dietary modifications, exercise, and behavioral therapy) did not adequately meet health targets of ≥5% weight loss.

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by WithMe Health, the health plan sponsor, or, if applicable, a state or federal regulatory agency.

_____ _____

Provider Signature Date