UPHP
UPPER PENINSULA HEALTH PLAN

Medicaid, Healthy Michigan Plan (HMP), and
Children's Special Health Care Services (CSHCS)

PHARMACY – ANTI-OBESITY PRIOR AUTHORIZATION REQUEST FORM

Fax this form to 1-888-656-3604

Date of Request: _____

PRIORITY LEVEL OF REQUEST:

☐ **Standard** *Decisions within 14 calendar days.*

☐ **Urgent** *Decisions within 72 hours, defined when the prescriber believes that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function.*

PRESCRIBER

Prescriber Name: _____ Direct Phone Number: _____
First *Last*

Prescriber NPI: _____ Fax Number: _____

Prescriber Specialty: _____

Name and title of person completing this form: _____

MEMBER

Member Name: _____ Medicaid ID Number: _____
First *Last*

Date of Birth: _____ Phone Number: _____

Member Address: _____

City: _____ State: _____ Zip: _____

Allergies: _____

DRUG

_____
Drug Name *Stength* *Dose/Frequency* *Formulation (tablet, capsule, gel, lotion etc.)*

Diagnosis (ICD-10 Code): _____ ☐ New Start ☐ Continuation

Previously tried and failed medications:

Name of Medication	*Reason for Failure*	*Dates*

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INITIAL

1. What is the patient's current BMI or height/weight (cm/kg)? _____

2. For adolescent patients age ≥ 12 years to < 18 years: what is the patient's BMI percentile per CDC growth chart for age and sex assigned at birth? _____

3. Does the patient have any of the following conditions? ☐ **YES** ☐ **NO**

a. If **YES**, please indicate which condition:

☐ Hypertension ☐ Coronary Artery Disease ☐ Diabetes ☐ Dyslipemia ☐ Sleep Apnea

4. Is this medication being prescribed for cardiovascular risk reduction in a patient with a prior myocardial infarction, prior stroke, or peripheral disease? ☐ **YES** ☐ **NO**

5. Will the patient use more than one weight loss medication in this class concurrently? ☐ **YES** ☐ **NO**

6. Does the patient have an eating disorder? ☐ **YES** ☐ **NO**

a. If **YES**, has treatment been optimized for treating the eating disorder and does the prescriber confirm the safety and appropriateness of this anti-obesity treatment? ☐ **YES** ☐ **NO**

7. Have metabolic or other reason(s) for obesity/symptoms been ruled out or diagnosed and treated (e.g., thyroid dysfuntion, diabetes, sleep apnea, etc.)? ☐ **YES** ☐ **NO**

8. Does the patient have any contraindications to use of the requested product, including pregnancy, lactation, a personal or family history of medullary thyroid cancer or multiple endocrine neoplasia type II? ☐ **YES** ☐ **NO**

9. Is medication therapy part of a total treatment plan including diet and exercise/activity as appropriate for the patient's ability? ☐ **YES** ☐ **NO**

10. Has the patient been informed weight may return with cessation of medication unless healthy lifestyle diet and activity changes, as appropriate for the patients, ability, are permanently adopted? ☐ **YES** ☐ **NO**

RENEWAL

1. Please provide clinical documentation (chart notes or vital signs summary) that includes both baseline AND current weight/height or BMI.

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UPHP Medicaid/HMP/CSHCS Formularies and prior authorization criteria are available on our website:

https://www.uphp.com/pharmacy/medicaidformularies/

Medical pharmacy requests (drugs administered by a provider) are submitted via the UPHP Assist Portal. Out-of-Network Providers may submit via fax using this form:

https://www.uphp.com/wp-content/uploads/pharmacy/UPHPMedicalPharmacyPARequestForm.pdf

Mail requests to:

Prime Therapeutics, LLC
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Phone: 1-888-274-2031