Reset Form Print Form

New Hampshire AIDS Drug Assistance Program
Prior Authorization Drug Approval Form
Weight Management Medications

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME: **FIRST NAME:**

MEDICAID ID NUMBER: **DATE OF BIRTH:** – –

GENDER: ☐ Male ☐ Female

Drug Name **Strength**

Dosing Directions **Length of Therapy**

SECTION II: PRESCRIBER INFORMATION

LAST NAME: **FIRST NAME:**

SPECIALTY: **NPI NUMBER:**

PHONE NUMBER: – – **FAX NUMBER:** – – –

SECTION III: CLINICAL HISTORY

For Imcivree™ requests, skip to question 16.

1. Patient's diagnosis: _____
2. Is the patient between 12 and 18 years of age (Saxenda®, Wegovy®, Xenical® only)? ☐ Yes ☐ No
   If **yes**, skip to **question 11**.
3. Is the patient 16 years of age or older (phentermine, Lomaira™) or 18 years of age or older (all drugs)? ☐ Yes ☐ No
4. Has the patient failed to lose weight on a low-calorie diet (1,200 kcal/day for women, 1,600 kcal/day for men) **and** exercise regimen after at least a 3-month trial? ☐ Yes ☐ No
   Explain: _____
5. Does the patient have a body mass index (BMI) of 30 kg/m^2 or more with no risk factors or 27 kg/m^2 or more with at least one high-risk factor or two other risk factors? ☐ Yes ☐ No
6. Patient's BMI: _____ Weight: _____ Height: _____ Date: _____
7. Waist Circumference: _____

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PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY *(continued)*

8. Does the patient have any of the following **high-risk** factors? (Check all that apply.)
   ☐ Sleep apnea ☐ Coronary heart disease ☐ Type 2 diabetes ☐ Atherosclerotic disease
9. Does the patient have any of the following risk factors? (Check all that apply.)
   ☐ Hypertension ☐ Gynecologic abnormalities ☐ Cigarette smoking ☐ Osteoarthritis ☐ Gallstones
   ☐ Dyslipidemia ☐ Family history of premature heart disease ☐ Impaired fasting glucose concentration
   ☐ Age (men more than 45 years, women more than 55 years or postmenopausal) ☐ Stress incontinence
10. Are there any contraindications to the use of this drug for this patient? ☐ Yes ☐ No
    If **yes**, explain then **skip to question 21**: _____
11. Is the patient's body weight more than 60 kg? ☐ Yes ☐ No
12. Does the patient's initial BMI correspond to 30 kg/m^2 for adults? ☐ Yes ☐ No
13. Is the patient higher than the 95th percentile on the pediatric growth chart? ☐ Yes ☐ No
14. Will the patient be maintained on a reduced calorie diet and increased physical activity? ☐ Yes ☐ No
15. Are there any contraindications to the use of this drug for this patient? ☐ Yes ☐ No
    If **yes**, explain, then **skip to question 21:** _____
16. Does the patient have a BMI 30 kg/m^2 or more or in the 95th or higher percentile on the pediatric growth chart? ☐ Yes ☐ No
17. Does the patient have a diagnosis of proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency, as confirmed by a genetic test? ☐ Yes ☐ No
18. Is the genetic variant pathogenic, likely pathogenic, or of uncertain significance? ☐ Yes ☐ No
19. Does the patient have a diagnosis of Bardet-Biedl Syndrome? **If yes, select all that apply.** ☐ Yes ☐ No
    ☐ Intellectual impairment ☐ Renal anomalies ☐ Polydactyly
    ☐ Retinal degeneration ☐ Genital anomalies
20. Is the prescriber an endocrinologist or geneticist, or has one been consulted? ☐ Yes ☐ No
21. Is there any additional information that would help in the decision-making process?
    If additional space is needed, please use a separate sheet.

Baseline body weight: _____ **Renewal body weight:** _____

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

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Prime THERAPEUTICS™