PRIOR AUTHORIZATION FORM – GLP-1S (ALL INDICATIONS)

Please fax the completed form to **(888) 219-0180**.

FOR WEIGHT LOSS INDICATION:

IF YOU ARE A PHYSICIAN OR CLINIC, PLEASE DO NOT FILL OUT THIS FORM. PLEASE REFER PATIENT TO BILH WEIGHT LOSS MANAGEMENT CLINIC (SEE CONTACT INFORMATION BELOW).

For GLP-1 to be covered for weight loss, plan members are required to complete a Medication Therapy Management (MTM) virtual visit with the BILH Weight Loss Management Clinic prior to receiving a GLP-1 weight loss product. To assist with this process, please refer your patient to the BILH Weight Management Team to answer questions and schedule a visit at below:

BILH WEIGHT LOSS MANAGEMENT CLINIC

- **Phone: 781-352-6551**
- **Fax: 339-227-4439**
- **E-mail: bilh-weightmanagementmtm@bilh.org**

Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data) to support the prior authorization request.

☐ **Check if Urgent** **The prescriber attests that applying the standard turnaround time could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.*

Patient Information: This must be filled out completely to ensure HIPAA compliance.					
First Name:	Last Name:		MI:	Phone Number:	
Address:	City:			State:	Zip Code:
Date of Birth:	☐ Male ☐ Female	Height (in/cm): _____ Weight (lb/kg):_____	Allergies:		
Baseline A1c and date drawn:			Current A1c and date drawn:		
Patient's Authorized Representative (if applicable):			Authorized Representative Phone Number:		

Insurance Information	
Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information			
First Name:	Last Name:	Specialty:	
Address:	City:	State:	Zip Code:
Requester (if different than prescriber):		Office Contact Person:	
NPI Number (individual):		Phone Number:	
DEA Number (if required):		Fax Number (in HIPAA compliant area):	
E-mail Address:			

Medication/Medical and Dispensing Information			
Medication Name: _____ ☐ Dispense as written ☐ Generic substitution permitted **If neither box is checked, PA Logic will review as "generic substitution permitted"*			
☐ New Therapy ☐ Renewal If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):			
Has the patient completed a Medication Therapy Management Consult with the Beth Israel Lahey Health Weight Loss Management Clinic? If no and indication is weight loss, please refer patient to Beth Israel Lahey Health Weight Loss Management Clinic before submitting prior authorization.			☐ Yes ☐ No
Pharmacy Name: _____ Pharmacy Phone Number: _____ Pharmacy Fax Number: _____			
Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity: _____ /30 days
Administration: ☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other			
Administration Location: ☐ Physician's Office Ambulatory ☐ Infusion Center	☐ Patient's Home Home Care ☐ Agency ☐ Outpatient Hospital Care	☐ Long Term Care ☐ Other (explain): _____	

PRIOR AUTHORIZATION FORM – GLP-1S (ALL INDICATIONS)

Patient Name:	ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review (e.g. chart notes, lab data) to support the prior authorization request.

1. List Diagnoses:	**ICD-10:**

2. Does the patient have Type 1 Diabetes? ☐ **YES (if yes, complete below)** ☐ **NO**

Date of Diagnosis	**Treatment History** (Specify Drug Name, Dose, and Dates)	**Response/Reason for Failure/Allergy**

3. What is the patient's current BMI?

BMI: _____

4. Does the patient have any comorbidities that should be considered with this diagnosis?

☐ **YES (if yes, complete below)** ☐ **NO**

Comorbidity	**Date of Diagnosis**	**Treatment History**

5. Has the patient tried any ORAL weight loss medications (e.g., Qsymia, Contrave, etc.)?

☐ **YES (if yes, complete below)** ☐ **NO**

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

6. Authorization Renewal: If the patient is already on GLP-1 treatment, has the patient lost ≥ 5% from their baseline body weight after 6 months of initiating GLP-1 therapy OR ≥ 10% of body weight within a year?

☐ **YES (if yes, complete below)** ☐ **NO** ☐ **N/A (initial determination)**

Baseline Weight (lb/kg): _____

Currrent Weight (lb/kg):_____

Baseline BMI:_____

Current BMI: _____

Treatment Start Date: _____

7. Required clinical information – Please provide all relevant clinical information to support a prior authorization review.

Please provide symptoms, lab results with dates, and/or justification for initial or ongoing therapy or increased dose, and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage (e.g., formulary tier exceptions) or required under state and federal laws.

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group, or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature: _____ **Date:** _____