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

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

To access PA forms online, please visit: https://paforms.com/inscript/
For inquiries regarding PA status and submission:

- Members/providers/pharmacies may contact 855-542-1819.
- Providers/pharmacies may contact 866-521-2323. Member calls will not be accepted.

FOR WEIGHT LOSS INDICATION ONLY:

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

Exceptions to Clinic Requirement:

- Type 1 Diabetes
- Pediatrics (age 0-17 years)

INSTRUCTIONS: Please fill out all applicable sections on both pages completely and legibly. **MUST** attach 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:
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.* ***If yes and indication is weight loss, visit date required for review.*	☐ Yes ☐ No Last Visit Date: _____

Pharmacy Name: _____

Pharmacy Phone Number: _____ Pharmacy Fax Number: _____

Dose/Strength:	Frequency:	Length of Therapy/# Refills:	Quantity/Day Supply: / days

Administration:

☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other

Administration Location:

☐ Physician's Office Ambulatory ☐ Patient's Home (Home Care Agency) ☐ Long Term Care

☐ Infusion Center ☐ Outpatient Hospital Care ☐ Other (explain):

_____

_____

Patient Age:

☐ 0-17 years ☐ 18+ years

**If age 18+ years, please refer to employee program.*

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Patient Name:	ID#:

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

1. Diagnosis for Drug Requested (*ICD-10 code and description*)**:**

2. Current Medication(s) for Diagnosis:

Drug Name/Strength/Form + Frequency	Plan to Discontinue? (Y/N)	Reason

3. Previous Medication(s) for Diagnosis:

Drug Name/Strength/Form + Frequency	Dates of Use (mm/yyyy)	Reason for Discontinuation

4. Is this a pediatric patient (age 0-17 years)? ☐ **YES** ☐ **NO**

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

Year of Diagnosis:

6. What is the patient's A1c before starting any GLP-1 therapy?

A1c before starting any GLP-1 therapy and date drawn:	Current A1c and date drawn:

7. What is the patient's BMI?

Current Weight (lb/kg):	Current BMI:

8. 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): Treatment Start Date:	Baseline BMI:

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

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

Comorbidity	Date of Diagnosis (mm/yyyy)	Treatment History

10. Is the patient a candidate for bariatric surgery? ☐ **YES** ☐ **NO**

11. <u>Required clinical information</u> – Please provide all relevant clinical information to support a prior authorization review.

- **PLEASE ATTACH** documentation of:
  - Symptoms
  - Lab results with dates to establish diagnosis or evaluate response
  - Justification for initial or ongoing therapy or increased dose
  - If patient has any contraindications for the health plan/insurer preferred drug(s)
  - Any additional clinical information or comments pertinent to this request for coverage (e.g., formulary tier exceptions) or required under state and federal laws.
- Please use the section below to describe any additional points for consideration.

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:** _____

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