Reset Form

New Hampshire Medicaid Fee-for-Service (FFS) Program
Prior Authorization/Non-Preferred Drug Approval Form

Anti-Obesity 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

1. **Patient's Diagnosis:**
2. **Has the patient failed to lose weight on a low calorie diet (1,200 kcal/day women, 1,600 kcal/day men) AND exercise regimen after at least a 3-month trial?** ☐ Yes ☐ No

   Please explain:
3. **Does the patient have BMI ≥ 30 kg/m^2 with no risk factors, or > 27 kg/m^2 with at least one (1) high risk factor, or two (2) other risk factors?** ☐ Yes ☐ No
4. **Patient's BMI:** **Weight:** **Height:** **Date:**
5. **Waist Circumference:**
6. **Does the patient have any of the following high risk factors?** ☐ Sleep apnea ☐ Type 2 diabetes ☐ Coronary heart disease ☐ Atherosclerotic disease
7. **Does the patient have any of the following risk factors?**

   ☐ Hypertension ☐ Dyslipidemia ☐ Cigarette smoking ☐ Osteoarthritis

   ☐ Gallstones ☐ Stress incontinence ☐ Gynecologic abnormalities ☐ Age (men > 45 years, women > 55 years or postmenopausal)

   ☐ Family history of premature heart disease ☐ Impaired fasting glucose concentration
8. **Are there any contraindications to the use of this drug for this patient?** ☐ Yes ☐ No

   If yes, please explain:
9. **Is there any additional information that would help in the decision-making process? If more space is needed, please use another page.**

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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