Priority Partners MCO
7231 Parkway Drive, Suite 100
Hanover, MD 21076

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS HEALTHCARE

Prior Authorization

JOHNS HOPKINS HEALTHCARE (MEDICAID)

Weight Loss Agents - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Healthcare at **1-410-424-4607**.
Please contact Johns Hopkins Healthcare at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Weight Loss Agents - Priority Partners MCO.

Drug Name (select from list of drugs shown)

Contrave (bupropion-naltrexone) | Saxenda (liraglutide) | Xenical (orlistat)

Quantity | Frequency | Strength

Route of Administration | Expected Length of Therapy

Patient Information
Patient Name: ______________________
Patient ID: ______________________
Patient Group No.: ______________________
Patient DOB: ______________________
Patient Phone:

Prescribing Physician
Physician Name: ______________________
Physician Phone: ______________________
Physician Fax: ______________________
Physician Address: ______________________
City, State, Zip: ______________________

Diagnosis: ______________________ **ICD Code:** ______________________

Comments: ______________________

Please circle the appropriate answer for each question.

1. Is this request for continuation of therapy after the initial 3 months of therapy?	Y N
[Note: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]	
[If no, then skip to question 3.]	
2. Has the prescriber documented a minimum of 5 percent weight loss from baseline weight?	Y N
[Note: Documentation must be submitted.]	

	[No further questions.]	
3.	Is this request for continuation of therapy after at least 6 months of maintenance therapy?	Y N
	[Note: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]	
	[If no, then skip to question 5.]	
4.	Has the patient gained back 50 percent or more of the original weight lost from baseline weight?	Y N
	[Note: Documentation must be submitted.]	
	[No further questions.]	
5.	Does the patient have a Body Mass Index (BMI) of at least 30 kilograms per meters squared?	Y N
	[Note: Documentation must be submitted.]	
	[If yes, then skip to question 7.]	
6.	Does the patient have a Body Mass Index (BMI) of at least 27 kilograms per meters squared with one or more of the following co-morbid conditions: A) Diabetes mellitus, B) Hypertension, C) Sleep apnea, D) Hyperlipidemia (high cholesterol), E) Symptomatic osteoarthritis of the lower extremities (knee or hip), F) Coronary heart disease?	Y N
	[Note: Coronary heart disease is shown by a history of any of the following: A) Heart surgery (bypass surgery or Coronary Artery Bypass Graft surgery), B) History of a heart attack (myocardial infarction), C) History of stroke, D) Angina.] \ [Note: Documentation must be submitted.]	
	[If no, then no further questions.]	
7.	Is the patient actively involved in a dietary/behavior modification program for weight loss?	Y N
	[Note: Documentation must be submitted.]	
	[If no, then no further questions.]	
8.	Is the patient pregnant or may become pregnant?	Y N
	[If yes, then no further questions.]	
9.	Is this request for Xenical?	Y N
	[If no, then skip to question 12.]	
10.	Does the patient have chronic malabsorption or cholestasis?	Y N
	[If yes, then no further questions.]	
11.	Is the patient 12 years of age or older?	Y N
	[No further questions.]	
12.	Is this request for Contrave or Saxenda?	Y N
	[If no, then no further questions.]	
13.	Does the patient have any of the following: A) Family history of medullary thyroid carcinoma, B) Renal	Y N

	impairment (Glomerular Filtration Rate less than 90 milliliters/minute/1.73 meters squared), C) Concomitant use with Insulin or Glucagon-like peptide-1 (GLP-1) agonists, D) Concomitant use with other weight loss medications, E) Hypersensitivity to any components of the medication?	
	[If yes, then no further questions.]	
14.	Is the patient 18 years of age or older?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date