HIGHMARK | HIGHMARK

Prescription Drug Prior Authorization Form

Fax to 1-866-240-8123

WEIGHT LOSS MEDICATIONS FORM

MEMBER INFORMATION

Subscriber's ID Number		Subscriber's Group Number	
Member's Name		Phone	Date of Birth
Address	City	State	Zip Code

PRESCRIBER INFORMATION

Physician's Name	NPI	Phone	Fax
Address	City	State	Zip Code
Suite / Building		Physician's Signature	Date

MEDICATION INFORMATION

Drug Name	Strength	Requested Quantity **per Month**
Diagnosis		

CLINICAL CRITERIA

1. Will the member be using the requested medication in combination with a reduced calorie diet and an exercise regimen?	Yes	No
2. Does the member have any of the following weight-related comorbidities? *Hypertension, Dyslipidemia, Type 2 diabetes mellitus, Obstructive sleep apnea, Symptomatic arthritis of the lower extremities, Gastroesophageal reflux disease, Coronary artery disease*	Yes	No
3. Does the prescriber attest to the following: the member has had active participation for at least 3 months in a lifestyle modification program that encourages reduced calorie diet and increased physical activity (e.g., increased physical activity, nutritional counseling, participation in a comprehensive weight management program) prior to initiation of the requested medication?	Yes	No
4. Please provide the member's **baseline** (prior to therapy with the requested medication): Height: _____ Weight: _____ Body Mass Index: _____		
5. If the member is currently on therapy with the requested medication:		
a. Please specify how long the member has been on therapy: _____		
b. Please provide the member's **current** (while on therapy with the requested medication): Height: _____ Weight: _____ Body Mass Index: _____		
c. Does the prescriber attest to the following: the member is using the requested medication in combination with a lifestyle modification program that encourages reduced calorie diet and increased physical activity (e.g., increased physical activity, nutritional counseling, participation in a comprehensive weight management program)?	Yes	No

6. If this request is for a glucagon-like peptide-1 receptor agonist (e.g. Saxenda, Wegovy, Zepbound, etc.): Will the member be using the requested medication in combination with a GLP-1 RA (glucagon-like peptide-1 receptor agonist) or GLP-1 RA combinations (e.g. Ozempic, Soliqua, etc.)?	Yes	No

7. Please provide any other medications previously tried and failed for the member's diagnosis:

_____

_____

The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the member. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Please print, type or write legibly in blue or black ink.
3. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
4. Please provide the physician address as it is required for physician notification.
5. Fax the **completed** form and all clinical documentation to **1-866-240-8123**
   Or mail the form to: **Clinical Services,**
   120 Fifth Avenue, MC PAPHM-043B, Pittsburgh, PA 15222