Prior Authorization Form

Fax form to: 888.647.6152

Bariatric Surgery

Priority Health

Clear Form

Member

Last name:_____ First name: _____

Contract #:_____ DOB:_____(Must be 18 years of age or older.)

Primary care physician: _____ Phone:_____ Fax: _____

Has PCP been notified of request? ☐ Yes ☐ No Hospital: _____

*Surgeon_____Phone:_____Fax:_____

Address:_____Surgery Date (if known):_____

Contact Name:_____Phone:_____Fax: _____

*Is the surgeon who will be performing the surgery a regular member of the American Society for Metabolic & Bariatric Surgery (ASMBS)? ☐ Yes ☐ No

Required

Medical obesity treatment may be provided by a credentialed physician with a declared interest in the medical treatment of obesity, the member's primary care physician (PCP) or other managing physician. Please refer to the *Medical Management of Obesity policy #91594* for specific criteria and documentation requirements which must be included (if applicable) when submitting this form.

Medical Management Program Supervised By (if required): _____

Dates of Attendance: _____

Clinical Condition

Current Weight: _____ Current Height:_____ *BMI:_____ Date weight and height measured_____

* BMI should be based upon measurement of height and weight within one month of requesting the surgery.

Check criteria that applies: ☐ BMI ≥ 35, participation in medical weight management program, and at least **one** of the obesity-related co-morbidities listed below.

☐ BMI ≥ 40, participation in medical weight management program

☐ BMI ≥ 50

Obesity-related co-morbidities (check all that apply and complete required information)

☐ Symptomatic sleep apnea requiring treatment Treatment (Check One): ☐ CPAP ☐ BI PAP ☐ Oral Appliance

☐ Significant cardiac disease/pulmonary disease (ASHD, RVH, LVH) Diagnosis_____

☐ Hypertension on one or more medications. Average B/P_____Meds/Dose_____

☐ Hyperlipidemia on therapy HDL/LDL_____Onset Date_____Meds/Dose_____

☐ Diabetes with HgbA1C > 7.0 requiring one or more medications or insulin. HgbA1C_____Onset Date_____
Orals Meds/Dose_____Insulin Therapy_____

☐ No co-morbidities present

Treatment requested

☐ Primary Bariatric Surgical (PBS) Treatment ☐ Revisional Bariatric Surgical (RBS) Treatment

Please select procedure being requested, including the CPT Code

☐ Roux en Y – **CPT Code** _____

☐ Laparoscopically Adjustable Banding (with an FDA approved device) – **CPT Code** _____

☐ Biliopancreatic Diversion with Duodenal Switch – **CPT Code** _____

☐ Sleeve Gastrectomy (specific criteria must be met) – **CPT Code** _____

☐ Other – **CPT Code** _____

Required

Need to include the following for medical review

☐ Surgeon Evaluation ☐ Internist Evaluation* ☐ Complete Psychological Evaluation (required for Medicaid members only)

*in some cases surgeon does medical evaluation also

If any of the following medical conditions are present, surgery is contraindicated.

☐ Pregnancy/lactation

☐ Severe psychopathology (based on a professional mental health evaluation)

☐ Medical conditions that make patient a prohibitive risk

☐ Any disease (e.g. cancer, uremia, liver failure), associated with a likelihood of survival less than 1 year

☐ Substance abuse including alcohol and other drugs of abuse. Six months of abstinence prior to surgery is required to meet this criterion.

☐ Tobacco use. *At least one month of abstinence prior to surgery is required to meet this criterion. The surgeon must require at least one month of tobacco abstinence prior to the surgical procedure. **Quit Date:** _____

***Please note surgery will not be approved unless abstinence criterion prior to surgery date is met.**

Print

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