



PA04 – WEIGHT REDUCTION REQUEST
NOT required for recipients less than 21 years of age.

Executive Office of Health & Human Services
PRIOR AUTHORIZATION REQUEST FORM for RI MEDICAID FEE FOR SERVICE (FFS)
DXC Technology ATTN: PHARMACIST
301 Metro Center Blvd., 3rd Floor • Warwick, RI 02886 • FAX (401) 784-3889

CLIENT NAME _____ DOB: _____ MEDICAID ID NUMBER: _____

PRESCRIBER NAME: _____ PRESCRIBER NPI #: _____

PRESCRIBER OFFICE ADDRESS: _____

OFFICE PHONE NUMBER: () _____

REQUESTER NAME: _____ RN /MD /R.Ph / _____

PHONE NUMBER: () _____ FAX NUMBER: () _____

DRUG REQUESTED: _____ QTY / FILL: _____

INDICATE THE RELEVANT DIAGNOSIS WITH APPROPRIATE ICD-10 CODE.

OBESITY ICD10 CODE: _____

Body Mass Index (BMI) _____ kg/m²
Client Weight _____
Client Height _____

EVIDENCE OF CO-MORBIDITY:
Diabetes Mellitus _____
Hypertension _____
Hyperlipidemia _____

APPROVAL OF REQUEST: _____
APPROVAL OF REQUEST: _____

INITIAL COVERAGE MONTHS 1 – 3 (3 MONTHS COVERED GRANTED)
CONTINUOUS COVERAGE MONTHS 4 – 6

EVIDENCE OF SUCCESS:

Weight at start of Treatment _____
Weight at end of 1st month _____
Weight at end of month 3 _____

(WEIGHT LOSS IN 1ST MONTH _____) MUST HAVE 4 LB. WEIGHT LOSS AT END OF 1ST MONTH
MUST MAINTAIN OR EXCEED 1ST MONTH WEIGHT LOSS AT THE END OF MONTH 3.

APPROVAL OF REQUEST: _____

CONTINUOUS COVERAGE MONTHS 7 – 11

EVIDENCE OF SUCCESS:

Weight at end of month 3 _____
Weight at end of month 6 _____

MUST MAINTAIN OR EXCEED WEIGHT LOSS AT THE END OF MONTH 3
MUST MAINTAIN OR EXCEED WEIGHT LOSS AT THE END OF MONTH 3

PRESCRIBER SIGNATURE _____ DATE _____

BY SIGNATURE, THE PRESCRIBER CONFIRMS THE CRITERIA INFORMATION ABOVE IS ACCURATE, VERIFIABLE BY CLIENT RECORDS AND AVAILABLE FOR REVIEW UPON REQUEST.

CONTACT DXC TECHNOLOGY CUSTOMER SERVICE FOR QUESTIONS 1-401-784-8100

FOR STATE USE ONLY:

APPROVAL: _____ YES _____ NO PRIOR AUTHORIZATION #: _____

EFFECTIVE DATES: FROM: _____ TO _____