

Service Authorization (SA) Form

WEIGHT-LOSS MANAGEMENT

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name:

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First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Medicaid ID Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of Birth:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

NPI Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Fax Number:

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DRUG INFORMATION

For initial requests, continue below. For renewal requests, proceed to page 4 of this form.

Drug Name: _____ Drug Form: _____

Drug Strength: _____ Dosing Frequency: _____

Length of Therapy: _____ Quantity: _____

Day Supply: _____

(Form continued on next page.)

Member's Last Name:

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Member's First Name:

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All approvals are subject to the criteria on this form. Existing authorizations will be honored until renewal.

Prescriber Signature (Required)

By signature, the physician confirms the above information is accurate and verifiable by member records.

Date

Please include ALL requested information. Incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328

Pharmacy PA call center: 1-800-310-6826