PRINT FORM

VENTURA COUNTY HEALTH CARE PLAN

Once completed, fax this form to (805) 658-4556

The Utilization Review Department can be reached at:

(805) 981-5060 Monday - Friday, 8:30am to 4:30pm PST

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Non-Urgent ☐ **Exigent Circumstances** ☐

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step-therapy exception request. **Information contained in this form is Protected Health Information under HIPAA.**

Patient Information: This must be filled out completely to ensure HIPAA compliance

First Name:	Last Name:	MI:	Phone Number:
Address:	City:	State:	Zip Code:
Date of Birth:	☐ Male ☐ Female	Circle unit of measure Height (in/cm): _____ Weight (lb/kg):_____	Allergies:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:	

Insurance Information

Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information

First Name:	Last Name:	Specialty:	
Address:	City:	State:	Zip Code:
Requestor (if different than prescriber):		Office Contact Person:	
NPI Number (individual):		Phone Number:	
DEA Number (if required):		Fax Number (in HIPAA compliant area):	
Email Address:		Requesting Facility/Clinic Name: **(Include Specific City Location)**	

Medication / Medical and Dispensing Information

Medication Name:	☐ Step Therapy Exception Request

☐ New Therapy ☐ Renewal

If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

How did the patient receive the medication?

☐ Paid under Insurance Name:_____ Prior Auth Number (if known):_____

☐ Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration:

☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration Location:	☐ Patient's Home	☐ Long Term Care
☐ Physician's Office	☐ Home Care Agency	☐ Other (explain):_____
☐ Ambulatory Infusion Center	☐ Outpatient Hospital Care	_____

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Patient Name:	ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request or step therapy exception request.

1. Has the patient tried any other medications for this condition? ☐ **YES (if yes, complete below)** ☐ **NO**

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

2. List Diagnoses:	**ICD-10 Diagnosis Code(s):**

3. <u>Required clinical information</u> - Please provide all relevant clinical information to support a prior authorization or step therapy exception request review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date**: _____

Plan/Insurer Use Only: Date/Time Request Received by Plan/Insurer: _____ Date/Time of Decision _____

Fax Number ( ) ___-___

☐ Approved ☐ Denied Comments/Information Requested: _____

VENTURA COUNTY HEALTH CARE PLAN

WEIGHT LOSS MEDICATION

PRIOR AUTHORIZATION REQUEST

Complete all applicable fields. Incomplete information may delay review.

1 MEMBER INFORMATION

Member Name:	**Date of Birth:**	Member ID:
Height:	**Current Weight:**	Current BMI:

2 PRESCRIBER INFORMATION

Prescriber Name:	**NPI:**	Contact Person:
Practice / Clinic:		
Phone:	**Fax:**	Date Submitted:

3 REQUEST INFORMATION

Request Type: ☐ **Initial Authorization**	☐ **Continuation Authorization**
Requested Medication: Strength/Dose: _____ Indication: ☐ Chronic weight management ☐ Other FDA-approved indication: _____	Date weight loss medication started: _____ Weight at initiation of therapy: _____ Current GLP-1 medication and strength/dose: _____ Requested GLP-1 medication Strength/Dose: _____

4 INITIAL AUTHORIZATION - COMPLETE FOR NEW STARTS

1	**Has the patient participated in a comprehensive weight-management program, including behavioral modification, a reduced-calorie diet, and increased physical activity, for at least 3 months?** If yes, specify: _____	☐ **Yes** ☐ **No**
2	**Is the member currently receiving another GLP-1 or anti-obesity medication?** If yes, specify: _____	☐ **Yes** ☐ **No**
3	**Does the patient have any weight-related comorbidities?** Baseline BMI: _____ ☐ BMI ≥ 30 kg/m² If BMI is 27–29.9, identify qualifying comorbidity: ☐ Hypertension ☐ Type 2 diabetes ☐ Dyslipidemia ☐ Cardiovascular disease ☐ Moderate to Severe Obstructive sleep apnea ☐ Other: _____	☐ **Yes** ☐ **No**
4	**Will the medication be used concomitantly with behavioral modification and a reduced-calorie diet?**	☐ **Yes** ☐ **No**

5	**Were the member's weight and height measurements obtained and documented by a healthcare professional during an in-person physical examination, rather than based solely on member-reported information?**	☐ Yes ☐ No

6	**Were the potential risks and proper use of the medication discussed with the patient?**	☐ Yes ☐ No

Clinical notes / additional information:

5 CONTINUATION AUTHORIZATION - COMPLETE FOR RENEWALS

Provide the baseline information used for the original authorization.

Baseline Weight:	Current Weight:	Percent Weight Loss:

1	**Has the patient achieved at least a 5% reduction from baseline body weight OR maintained the initial ≥5% reduction from baseline?** **OR** **For Patient with Obstructive Sleep Apnea Moderate to Severe (using Zepbound)** **Has the patient lost ≥10% of baseline body weight?**	☐ Yes ☐ No
2	**Will the medication continue to be used in conjunction with behavioral modification, a reduced-calorie diet, and increased physical activity?**	☐ Yes ☐ No
3	**Were the member's weight and height measurements obtained and documented by a healthcare professional during an in-person physical examination, rather than based solely on member-reported information?**	☐ Yes ☐ No
6	**Were the potential risks and proper use of the medication discussed with the patient?**	☐ Yes ☐ No

Clinical notes / additional information:

6 PRESCRIBER ATTESTATION

I attest that the information provided is complete and accurate to the best of my knowledge.

Prescriber Signature:	Date:

FOR PLAN USE ONLY

Date Received:	**Reviewer:**
Decision: ☐ **Approved** ☐ **Denied** ☐ **More Information Needed**	**Authorization Period:**
Comments:	