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)
Gainwell Technologies 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: _______ **INITIAL COVERAGE MONTHS 1 – 3 (3 MONTHS COVERED GRANTED)**
APPROVAL OF REQUEST: _______ **CONTINUOUS COVERAGE MONTHS 4 – 6**

EVIDENCE OF SUCCESS:
Weight at start of Treatment __________
Weight at end of 1st month __________ (WEIGHT LOSS IN 1ST MONTH_______) MUST HAVE 4 LB. WEIGHT LOSS AT END OF 1ST MONTH
Weight at end of month 3 __________ 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 __________ MUST MAINTAIN OR EXCEED WEIGHT LOSS AT THE END OF MONTH 3
Weight at end of month 6 __________ 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 GAINWELL TECHNOLOGIES CUSTOMER SERVICE FOR QUESTIONS 1-401-784-8100

FOR STATE USE ONLY:

APPROVAL: _____YES _____NO PRIOR AUTHORIZATION #: ________________________

EFFECTIVE DATES: FROM: ____________________________TO _________________________

Revised 10.2020