Reset Form Print Form

**New Hampshire Medicaid Fee-for-Service (FFS) Program**
**Prior Authorization Drug Approval Form**
Weight Management Medications

**DATE OF MEDICATION REQUEST: / /**

## SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

**LAST NAME:** **FIRST NAME:**

**MEDICAID ID NUMBER:** **DATE OF BIRTH:** – –

**GENDER:** ☐ Male ☐ Female

**Drug Name** **Strength**

**Dosing Directions** **Length of Therapy**

## SECTION II: PRESCRIBER INFORMATION

**LAST NAME:** **FIRST NAME:**

**SPECIALTY:** **NPI NUMBER:**

**PHONE NUMBER:** – – **FAX NUMBER:** – – –

## SECTION III: CLINICAL HISTORY

1. Is the request for a GLP-1 and/or GIP receptor agonist? (if yes, PA forms for alternate indications should be used) ☐ Yes ☐ No
2. Is the patient 12 years of age and older (phentermine/topiramate, orlistat) or 16 years of age and older (phentermine, Lomaira)? ☐ Yes ☐ No
3. Has the patient failed to lose weight on a low-calorie diet (1,200 kcal/day for women, 1,600 kcal/day for men) **and** increased physical activity for at least a 3-month trial? ☐ Yes ☐ No

   Explain if no: _____
4. Does the patient have a body mass index (BMI) of 30 kg/m$^2$ or more with no risk factors or 27 kg/m$^2$ or more with at least one high-risk factor or two other risk factors? ☐ Yes ☐ No
5. Patient's BMI: _____ Weight: _____ Height: _____ Date: _____



Revision Date: 01/01/2026

**New Hampshire Medicaid Fee-for-Service (FFS) Program**
**Prior Authorization Drug Approval Form**
Weight Management Medications

**PATIENT LAST NAME:** | | | | | | | | | | | | |

**PATIENT FIRST NAME:** | | | | | | | | | | | | |

**SECTION III: CLINICAL HISTORY *(continued)***

6. Waist Circumference: _____
7. **Pediatric patients**: Is the patient's body weight more than 60 kg? ☐ Yes ☐ No
8. **Pediatric patients**: Does the patient's initial BMI correspond to 30 kg/m$^2$ for adults? ☐ Yes ☐ No
9. **Pediatric patients:** Is the patient higher than the 95th percentile on the pediatric growth chart? ☐ Yes ☐ No
10. Does the patient have any of the following **high-risk** factors? (Check all that apply.)
    ☐ Sleep apnea ☐ Coronary heart disease ☐ Type 2 diabetes ☐ Atherosclerotic disease
11. Does the patient have any of the following risk factors? (Check all that apply.)
    ☐ Hypertension ☐ Gynecologic abnormalities ☐ Cigarette smoking ☐ Osteoarthritis ☐ Gallstones
    ☐ Dyslipidemia ☐ Family history of premature heart disease ☐ Impaired fasting glucose concentration
    ☐ Age (men more than 45 years, women more than 55 years or postmenopausal) ☐ Stress incontinence
12. Are there any contraindications to the use of this drug for this patient? ☐ Yes ☐ No
    If **yes**, explain: _____
13. Is there any additional information that would help in the decision-making process?
    If additional space is needed, please use a separate sheet.

**Baseline body weight:** _____ **Renewal body weight:** _____

**I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.**

**PRESCRIBER'S SIGNATURE**: _____ **DATE**: _____