# STAGE 2 Bariatric Surgery Request

Please fax completed form to **Fax: 1-877-212-6669.** Information marked with an asterisk (*) is required for processing. Please contact the Prior Authorization Department at **1-877-644-4613** with any questions.

## SECTION 1: GENERAL INFORMATION

### PROVIDER INFORMATION

| *Name of primary care provider who will supervise weight loss if client is approved for Stage 2 | *Provider NPI |
|---|---|
| *Provider TIN | |
| *Contact Name and Telephone | *Fax |

### CLIENT INFORMATION

| *Member name | Date of Birth | *Medicaid or Coordinated Care ID |
|---|---|---|
| *Current weight (within last month)<br>Pounds: Date weighed: | *Height | *ICD-9/10 |
| Start Date for Stage 2 Request: | End Date will be 6 months from Start Date. Please fax in for extension requests if necessary. | |

**If any non-participating providers will be providing Stage 2 Care for the member please list out below for authorization, including office visits, nutritional counseling, psychosocial evaluation, or specialty care:**

**Non par providers must be included on this form for authorization to cover services.**

| Name: | TIN: | NPI: | CPTs: | Units/#Visits |
|---|---|---|---|---|
| | | | | |

## SECTION 2: QUALIFYING QUESTIONS - WAC 182-531-1600(6)*

**Is the client between age 18 - 59 years?** ☐ **YES** ☐ **NO (If >59, may be considered.)**

**Client's BMI _____** ☐

**Is the client pregnant?** ☐ **YES** ☐ **NO**

If you answer yes to any of the following questions, the client may qualify for bariatric surgery. Complete the rest of the form and submit required documentation. (* as appropriate)

coordinated care™

**1. Does this client have diabetes?**

☐ **YES** (complete the following then skip to section 3)

a. Date of diabetes diagnosis:

b. Which test documents the client has diabetes?

☐ Hemoglobin A1c 6.5 or greater (Provide a copy of a diagnostic lab value. If newly diagnosed, send two qualifying A1c tests three months apart or one A1c and one of the following tests.)

☐ Random glucose > 200mg/Dl (Provide a copy of the diagnostic lab value.)

☐ 2-hour oral glucose tolerance test (Provide a copy of the diagnostic lab value and reference range.)

c. What diabetes medications does the client use at this time?

☐ **NO** (move to question 2)

**2. Does this client have Degenerative Joint Disease (DJD) of a major weight-bearing joint and is currently a candidate for replacement if weigh loss is achieved?**

☐ **YES** (complete the following then skip to section 3)

a. Provide the following documentation:

☐ Diagnostic Imaging report documenting severe DJD and

☐ An orthopedic consult recommending joint replacement as soon as weight loss is achieved

☐ **NO** (move to question 3)

**3. Does this client have a rare comorbid condition for which there is medical evidence bariatric surgery is medically necessary and the benefits of bariatric surgery outweigh the risk of surgical mortality?**

☐ **YES** (complete the following then skip to section 3)

a. What is the rare comorbid medical condition?

b. Provide documentation client has the medical condition and how bariatric surgery is medically necessary treatment

☐ **NO** Please describe the case and document the medical necessity of bariatric surgery.

## SECTION 3: ADDITIONAL INFORMATION

**List all comorbidities <u>related to obesity</u>.**

| | |
|---|---|
| **Required labs** (attach lab reports with the documentation) | A1c from past three months (if not diabetic, from within the past year): Date: |
| | TSH or thyroid studies within the past year:<br>TSH: Other thyroid studies: |
| | Recent liver function tests (LFTs):<br>AST: ALT: Bilirubin: ALK PHOS: |
| | Recent kidney function tests:<br>BUN: Creatinine: eGFR: |

**During the time this client has been your patient, describe the weight loss/diet recommendations and support you have provided him/her. Why do you think this has not been successful?**

**Previous formal weight loss programs (list each program and approximate dates of participation).**

| Weight Loss Program | Approximate Dates |
|---|---|
| **a.** | **thru** |
| **b.** | **thru** |
| **c.** | **thru** |
| **d.** | **thru** |

**Do you think this client has the ability to maintain the post-operative dietary changes required for success?** ☐ Yes ☐ No

Why or why not?

Please attach required records in the following order:

1. Diabetes-related labs, if diabetic
2. Diagnostic imaging reports and orthopedic consult, if PT requires joint replacement
3. Detailed history and physical (required for each client requesting bariatric surgery)
4. Other lab work
5. Other supporting and relevant documentation you would like us to review

*** If this member is approved for stage 2 of the bariatric surgery program, as the member's primary care provider, I agree to partner with the client to meet the requirements of the program. ☐ Yes ☐ No

**Fax: 1-877-212-6669**