Stage 2 Bariatric Surgery Request

COMMUNITY HEALTH PLAN of Washington™

For Apple Health Plans:
Prior Authorizations requests may be faxed to:
206-613-8873

Please call Customer Service to verify eligibility & benefits:
1-800-440-1561
Monday through Friday, 8a.m. - 5p.m.

- Prior Authorization Requests may be made through the Medical Management Portal at www.chpw.org/submitcare
- Please attach supporting clinical information to this fax.
- Incomplete forms and requests without clinical information will delay processing.

SECTION 1: GENERAL INFORMATION

Provider Information

REQUESTING PROVIDER INFORMATION:

**Name of primary care provider who will supervise weight loss if client is approved for Stage 2*

Tax ID:	Contact Name:	Contact Phone #:	Contact Fax #:

SERVICING PROVIDER INFORMATION:

Facility who will perform the bariatric surgery

Member Information

Member Name:		Date of Birth:	CHPW Member ID:

Current Weight (within last month)	Date Weighed:	Height:	ICD 10/Dx codes:

SECTION 2: QUALIFYING QUESTIONS

source WAC 182-531-1600(6)

Is the member between ages 18-59 years? ☐ **YES** ☐ **NO** (If greater than 59 may be considered)

Is the member's BMI 35or greater? _____

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

1. Does the member 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 member use at this time?

☐ **NO** (move to question 2)

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

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

a. Provide the following documentation:
- Diagnostic imaging report documenting sever DJD
- An orthopedic consult recommending joint replacement as soon as weight loss is achieved

☐ **NO** (move to next question)

3. Does this member 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)

a. What is the rare comorbid medical condition?
b. Provide documentation member 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 related to obesity:

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

Does the member have mental health or substance abuse issues that may interfere with successful participation in a weight loss program? ☐ **YES** ☐ **NO**

Please attach required documentation in the following order:
1. Diabetes-related lab (if diabetic)
2. Diagnostic imaging reports and orthopedic consult (if PT requires joint replacement)
3. Detailed history and physical (required for each member 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 bariatric surgery program, as the member's primary care provider, I agree to partner with the member to meet the requirements of the program. ☐ **YES** ☐ **NO**

Provider Signature: _____