Washington State Health Care Authority

STAGE 2 Bariatric Surgery Request

After January 1, 2015, clients requesting the bariatric surgery program will need to request authorization for stages 2 and 3 from the client's assigned managed care plan. Contact the managed care plan directly for instructions on how to submit an authorization request.

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
Telephone	Fax

CLIENT INFORMATION

Client name		ProviderOne ID
Current weight (within last month) Pounds: Date weighed:	Height	Name of Managed Care Plan

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

Is the client between age 18 - 59 years? ☐ **YES** ☐ **NO (If >59, may be considered.)**
Is the client's BMI 35 or greater? ☐ **YES** ☐ **NO**
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.

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: TSH: Other thyroid studies:
	Recent liver function tests (LFTs): AST: ALT: Bilirubin: ALK PHOS:
	Recent kidney function tests: 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 client is approved for stage 2 of the bariatric surgery program, as the client's primary care provider, I agree to partner with the client to meet the requirements of the program. ☐ Yes ☐ No ***

Fax: 1-866-668-1214 or mail to: Medical Request Coordinator-Apple Health
Washington State Health Care Authority, PO Box 45535; Olympia, WA 98504-5535

A typed and completed General Authorization for Information form, 13-835, must be attached to your request in order to be processed by the Health Care Authority.