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Prior Authorization Request Form	Bariatric Surgery
Standard Fax Number: 1 (844) 807-8997	**Urgent Fax Number:** 1 (844) 807-8996

Use AuthAccel - Blue Shield's online authorization system - to complete, submit, attach documentation, track status, and receive determinations for both medical and pharmacy authorizations. Visit Provider Connection (www.blueshieldca.com/provider) and click the Authorizations tab to get started.

Notice: Blue Shield of CA has a 5 Business Day turn-around time on all Standard Prior Authorization Requests. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

☐ New Standard Request ☐ New Urgent Request ☐ Standing Referral

Important For Urgent Requests: Scheduling issues do not meet the definition of an urgent request. The definition of an urgent request is an imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision-making might seriously jeopardize the life or health of the enrollee. ***If there is no MD signature present the request will be processed as a Standard request.***

MD Signature REQUIRED For Urgent Requests Only:

☐ Modification Or ☐ Extension Requests Complete the Section Below:

Date Last Authorized:	Previous Authorization Number:
MD/NP/PA justification for modification or extension:	

Patient Information:

First Name:	Last Name:
Date of Birth:	ID Number:
Address:	

Referring/Prescribing Provider:

Name:			NPI:	
Street Address + Suite #:				
City:	State:	Zip:	Phone:	Fax:
Type of Provider: ☐ PCP ☐ Specialist Type:			Contact Name and Phone Number:	

Servicing/Billing: Provider/Vendor/Lab *If same as Referring/Prescribing Provider Check Here* ☐

Name:	Tax ID:	NPI:
Street Address + Suite #:		

City:	State:	Zip:	Phone:	Fax:
Specialist Type:			Contact Name and Phone Number:	

If Servicing Provider is billing as part of a Group Contract enter the Group Name and Address:

Group Name:		NPI:
Street Address + Suite #:		
City:	State:	Zip:

Billing Facility (If Applicable):

Facility Name:		NPI:	
Street Address + Suite #:			
City:	State:	Zip:	Phone:	Fax:
Contact Name and Phone Number:				

Anticipated Date of Service:	**If Lab, Draw Date:**

Place of Service: (Check One Box Only or If typing replace box with an "X"):

☐ Office	☐ Home	☐ On Campus OP Hosp
☐ Acute Rehab	☐ Hospice	☐ PHP
☐ Ambulance- Air or Water	☐ Independent Clinic	☐ RTC – Psychiatric
☐ Ambulance-Land	☐ Independent Laboratory	☐ RTC – SUD
☐ Ambulatory Surgical Center	☐ Inpatient Hospital	☐ Skilled Nursing Facility
☐ Assisted Living Facility	☐ Intermediate Care Facility	☐ Telehealth
☐ Birthing Center	☐ IOP	☐ Urgent Care Facility
☐ Custodial Care Facility	☐ IP Psychiatric Facility	☐ Other - Please Specify:
☐ End Stage Renal Disease Tx	☐ Nursing Facility	
☐ Group Home	☐ Off Campus OP Hosp	

Please enter all codes requested; unlisted codes must have a description.
Please include the quantity for each code requested and if applicable, left, right or bilateral designations.

ICD-10 Code(s):

CPT/HCPC Code(s):

For questions: Call BSC Medical Care Solutions Phone Number: 1-800-541-6652

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PATIENT CLINICAL INFORMATION

Please provide the following documentation:

☐ **Initial Bariatric Procedure in Adults with Morbid Obesity:**

- ☐ History and physical and/or consultation notes including prior weight loss attempts and responses, and comorbidities (if needed):
  - ☐ A body mass index (BMI) greater than 35.0 kg/m^2 or for adolescents 140% of the 95th percentile for age and sex (whichever is lower)
    OR
  - ☐ If BMI is greater than or equal to or equal to 30 kg/m^2 (27.5 kg/m^2 for Asian individuals) and less than 35.0 kg/m^2) or for adolescents 120% of the 95th percentile for age and sex (whichever is lower), documentation of at least one of the following comorbidities, including, but not limited to:
    - ☐ Coronary artery disease: Submit documentation of at least one of the following:
      - ☐ Stress study
      - ☐ Coronary angiography
      - ☐ Heart failure
      - ☐ History of prior myocardial infarction
      - ☐ Prior coronary artery bypass
      - ☐ Prior percutaneous coronary intervention
    - ☐ Diabetes: Submit documentation from primary care provider or endocrinologist of the diagnosis and treatment
    - ☐ Hypertension: Submit documentation showing a blood pressure of greater than 140 mm Hg systolic and/or 90 mmHg diastolic in spite of concurrent use of at least 3 anti-hypertensive drugs, one of which may be a diuretic
    - ☐ Obstructive sleep apnea (OSA): Submit documentation of clinically significant OSA such as an official sleep study report interpreted by a sleep disorders specialist MD or Doctor of Osteopathic (DO) medicine showing an Apnea Hypopnea Index (AHI) of at least 15 events per hour, or at least 5 events per hour in addition to excessive daytime sleepiness or hypertension; or obesity hypoventilation syndrome as shown by an awake arterial blood gas or serum bicarbonate level
    - ☐ Osteoarthritis: Submit documentation that includes radiographic reports confirming the diagnosis
    - ☐ Hyperlipidemia: Submit documentation of an LDL cholesterol of 160 mg/dl or higher despite dieting and medical treatment
    - ☐ GastroEsophageal Reflux Disease (GERD): Submit documentation showing endoscopic findings or an ambulatory pH monitoring report that supports the diagnosis and failure of maximal medical therapy
    - ☐ Idiopathic intracranial hypertension: Submit documentation showing laboratory or imaging findings that supports diagnosis
    - ☐ Nonalcoholic steatohepatitis: Submit documentation showing laboratory, imaging or pathology findings that confirms diagnosis
    - ☐ Blount disease: Submit documentation showing history, physical or imaging findings that supports diagnosis
    - ☐ Slipped capital femoral epiphysis: Submit documentation showing imaging findings that supports diagnosis
- ☐ Description of medically supervised non-surgical weight-reduction program, initial weight, end weight, duration (start and end dates)) and any pharmacologic agents used (including intolerance if applicable)

For questions: Call BSC Medical Care Solutions	**Phone Number: 1-800-541-6652 Option 6**

PATIENT CLINICAL INFORMATION

- ☐ Documented failure of weight reduction to a BMI less than 30 kg/m^2 (27.5 kg/m^2 for Asian individuals) by conservative measures for 3 of the past 6 months
- ☐ Medical records that include current height, weight, and body mass index (BMI), surgery requested, and any other recommendations
- ☐ Documented educational counseling/class
- ☐ Signed Psychosocial-behavioral checklist
- ☐ Signed Pre-operative checklist

☐ **Revision Bariatric Surgical Requests for Complications:**

- ☐ Documentation of the problem needing correction (history and physical and/or consultation notes including: prior surgery and complications as applicable, indication for surgery, and treatment plan), which may include, but are not limited to:
  - ☐ Staple-line failure or leakage
  - ☐ Obstruction, stricture, erosion, or fistula
  - ☐ Gastroesophageal reflux disease (GERD), based on ambulatory pH probe monitoring, or endoscopic findings of ulcer, strictures, Barrett's esophagus, or esophagitis and failing maximal medical therapy
  - ☐ Pouch enlargement documented by endoscopy and prior successful weight loss
  - ☐ Nonabsorption resulting in hypoglycemia or malnutrition
  - ☐ Weight loss of 20% or more below ideal body weight
  - ☐ Band slippage or herniation that cannot be corrected with manipulation or adjustment

☐ **Revision Bariatric Surgical Requests for Inadequate Weight Loss:**

- ☐ Documentation requested for Initial Bariatric Procedure in Adults with Morbid Obesity
- ☐ Post-surgical weight loss history (including pre- and post-surgical BMI), nutrition and exercise compliance
- ☐ Operative report(s) (if applicable)
- ☐ Documentation at least 2 years have passed since the initial procedure
- ☐ Inadequate weight loss resulted from initial procedure; less than 50% expected weight loss and/or weight remains greater than 40% over ideal body weight (normal body weight BMI parameter = 18.5-24.9)

☐ **Bariatric Surgery in Adolescents:**

- ☐ Documentation requested for Initial Bariatric Procedure in Adults with Obesity
- ☐ Documentation of psychological counseling
- ☐ Documentation of informed consent
- ☐ Documentation that any device used for bariatric surgery is in accordance with the FDA-approved indication for use

☐ **Concomitant Hiatal Hernia Repair:**

- ☐ Documentation of preoperatively-diagnosed hiatal hernia with indications for surgical repair

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Let's Talk Bariatric Surgery

One of the most important factors in helping you choose appropriate medical care is your comprehensive understanding of the reasons for treatment, the risks, and the potential benefits. Weight loss surgery (bariatric surgery) is a treatment option for people with severe obesity (body mass greater than 40 or 100 or more pounds over the ideal body weight). Bariatric surgery can help you lose approximately 50-80% of your excess weight but your ***success will ultimately depend on your own commitment to follow lifelong dietary restrictions, adhere to an exercise program, take dietary supplements and comply with follow-up recommendations.*** *If bariatric surgery has been suggested to you as an option for your particular problem, you should carefully weigh the pros and cons, the alternative treatments, and the potential benefits and risks.*

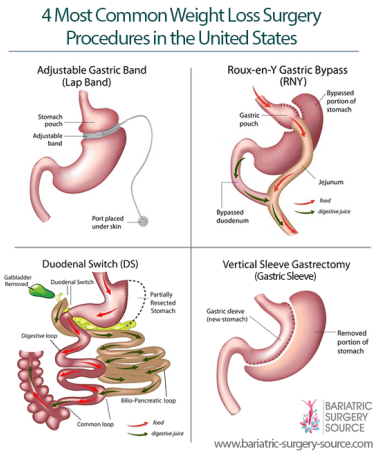
Should You Have Bariatric Surgery?

Talk to your doctor and become an active partner in making an informed decision about whether bariatric surgery is right for you.

- How will bariatric surgery help me?
- Are there other ways of losing weight that I should try first?
- What are the risks of each of my treatment options?
- What should I expect about eating and diet after the surgery?
- Why might this treatment not be right for me?
- If I am not committed to lifestyle modification will surgery still help me long-term?

The Procedure

Type of Surgery	Roux-En-Y Gastric Bypass	Vertical Sleeve Gastrectomy	Adjustable Gastric Band (Lap Band®)	Biliopancreatic Bypass with Duodenal Switch
Most Common[2]	23.1%	53.8%	5.7%	0.6%
Average Weight Loss	65-80%	50-70%	40-50%	70%
Surgical Risk	Moderate	Low-Moderate	Low	High
Most Effective For	BMI 35-55	High Risk or High BMI (>60)	Diet & Exercise Compliance	BMI >50
Advantages	More Permanent Weight Loss	Restricts Volume of Food Eaten	Safest Procedure	Most Side Effects but Most Effective



Shared Decision

Please check each box

A. Do you understand the options available to you?
Yes ☐ No ☐

B. Are you clear about which benefits and side effects matter most to you?
Yes ☐ No ☐

C. Do you have enough information to make an informed choice?
Yes ☐ No ☐

D. Do you feel comfortable about your decision?
Yes ☐ No ☐

These websites offer more information: www.stopobesityalliance.org / www.asmbs.org / www.smartpatient.com/gastricbypass / www.win.niddk.nih.gov/publications/gastric.htm

Physician Signature:_____
Date:_____/_____/_____

Patient Signature:_____
Date:_____/_____/_____

Your signature ensures you feel confident that you and your doctor have explored all of your options and you understand everything fully and that together you are making the decision that is best for you.

Information compiled from: Centers for Disease Control and Prevention, American Society for Metabolic and Bariatric Surgery, The Mayo Clinic, U.S. Department of Health and Human Services, The Obesity Society, American Association of Clinical Endocrinologists, Scripps Health, University of Michigan Bariatrics, Stanford University Bariatrics & Fresno Bariatric and Metabolic Hospital *Ponce, Jaime et al. American Society for Metabolic and Bariatric Surgery estimation of bariatric surgery procedures in 2015 and surgeon workforce in the United States. Surg. Obes. Relat. Dis., 2016; 12(9): 1637-1639

collaboRATE™

Thinking about the appointment you have just had ...

1. How much effort was made to help you understand your health issues?

No effort was made — Every effort was made

2. How much effort was made to listen to the things that matter most to you about your health issues?

No effort was made — Every effort was made

3. How much effort was made to include what matters most to you in choosing what to do next?

No effort was made — Every effort was made

Your signature ensures you feel confident that you and your doctor have explored all of your options and you understand everything fully and that together you are making the decision that is best for you.

Patient Signature:_____ Date:____/____/____

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Blue Shield of California Checklist for Bariatric Surgery

No	Procedure	Yes	No
1.	A complete History & Physical has been performed. (obesity-related co- morbidities, causes of obesity, weight/BMI, weight loss history, level of commitment, and exclusions related to surgical risk)	◯	◯
2.	Routine labs have been completed. (fasting blood glucose and lipid panel, kidney function, liver profile, lipid profile, urine analysis, prothrombin time/INR, blood type, CBC)	◯	◯
3.	If the patient is a diabetic, an optimized glycemic control has been completed.	◯	◯
4.	Nutrient screening with iron studies, B12, 25-vitamin D and folic acid have been completed. (Or more extensive testing in patients undergoing malabsorptive procedures based on symptoms and risks)	◯	◯
5.	Cardiopulmonary evaluation with sleep apnea screening has been completed. (ECG, CXR, echocardiography if cardiac disease or pulmonary hypertension suspected)	◯	◯
6.	GI evaluation has been completed. (H. pylori screening in high-prevalence areas, gallbladder evaluation)	◯	◯
7.	Endocrine evaluation has been completed. (A1c with suspected or diagnosed pre-diabetes or diabetes; TSH with symptoms or increased risk of thyroid disease; androgens with PCOS suspicion; total/bio-available testosterone, DHEAS, androstenedione)	◯	◯
8.	A pre-operative assessment, clinical nutrition evaluation, and post-operative plan for dietary intake has been completed by a Physician, Registered Dietician (RD), or other licensed professional experienced in patient care with bariatric surgery. (The pre-operative assessment must document that the patient has a good understanding of the diet and nutritional changes that are associated with bariatric surgery and has the capacity to comply with these changes, long term. The post-operative plan should include the evaluation of other issues that could affect nutrient status, including readiness for change, realistic goal setting, general nutrition knowledge, as well as behavioral, cultural, psychosocial, and economic concerns of the patient).	◯	◯
9.	Informed consent completed, including evaluation of the patient's understanding of the procedure, the procedure's risks and benefits, length of stay in the hospital, behavioral changes required prior to and after the surgical procedure. (including dietary and exercise requirements, follow up requirements, and anticipated psychological changes)	◯	◯
10.	A plan to continue efforts for preoperative weight loss has been completed.	◯	◯
11.	The Bariatric Surgery Decision Aid has been discussed with the patient, the patient has signed and the form has been sent to Blue Shield of CA as a part of prior authorization.	◯	◯
12.	The CollaboRATE survey has been filled out by the patient and sent to Blue Shield of CA as a part of prior authorization.	◯	◯
13.	Remaining compliant with 42 CFR Part 2 (Confidentiality of Substance Use Disorder Patient Records), to your knowledge, has the patient been appropriately screened for substance abuse within the past year?	◯	◯
14.	Pregnancy counseling, if needed, has been completed.	◯	◯
15.	Smoking cessation counseling has been completed.	◯	◯
16.	Verification of cancer screening by a Physician has been completed.	◯	◯

Bariatric surgeon's name: _____ **Date:** _____

Bariatric surgeon's signature: _____

License Number: _____

I have reviewed this patient's clinical information and recommend that they have the requested Bariatric surgery. By signing this documentation, I attest that the information contained above is correct, to the best of my knowledge, and that clinical records substantiating this documentation are available for review, if requested.

Note: Adapted from the Clinical Practice Guidelines for the Perioperative Nutritional, Metabolic, and Nonsurgical Support of the Bariatric Surgery Patient, Cosponsored by American Association of Clinical Endocrinologists, The Obesity Society, and American Society for Metabolic & Bariatric Surgery, published March 2013

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Blue Shield of California Psychosocial Behavioral Checklist

MUST BE COMPLETED BY THE QUALIFIED MENTAL HEALTH PROFESSIONAL WHO COMPLETED THE COMPREHENSIVE PSYCHOSOCIAL BEHAVIORAL EVALUATION IN CONSULTATION WITH THE BARIATRIC SURGEON

1) A clinical interview has been completed.
   ◯ Yes ◯ No

2) In addition to a clinical interview and review of history was any psychological testing performed? If yes, what test(s)?

   _____

   _____

   _____

3) Is the patient willing and able to comply with the requisite dietary and behavioral modifications? ◯ Yes ◯ No

4) Is the patient competent to make medical decisions on their own behalf?
   ◯ Yes ◯ No

5) Is the patient willing and able to make the lifetime commitment required for a successful outcome? ◯ Yes ◯ No

6) In your professional opinion, there are no clear contraindications psychiatrically for the patient's bariatric surgery? ◯ Yes ◯ No

*If you answered 'no' to any of the above items, please include additional documentation as an attachment that explains the rationale.

By signing this documentation, I attest that the information contained above is correct, to the best of my knowledge, and professional judgement and that clinical records substantiating this documentation are available for review, if requested.

Provider's name: _____

Provider's signature: _____

License # _____

Date: _____

Note:
Psychosocial assessment must follow American Society for Metabolic and Bariatric Surgery (ASMBS) guidelines - https://asmbs.org/resources/recommendations-for-the-presurgical-psychosocial-evaluation-of-bariatric-surgery-patients.