

TEXAS HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID/CHIP VENDOR DRUG PROGRAM

Orlistat (Xenical®) Prior Approval Request Form

REQUESTS FOR XENICAL® IN OBESITY MANAGEMENT WILL BE DENIED

The Health Care Financing Administration has mandated that Texas Medicaid cover Xenical® therapy for the treatment of hyperlipidemia only. Xenical® will not be approved for concurrent use with other cholesterol lowering agents. **Prior approval requests must include a recent lipid profile and will receive review based on the following criteria:**

**Total cholesterol greater than 200 mg/dl
LDL greater than 130 mg/d
HDL less than 40 mg/dl
Body weight and height (BMI)**

The maximum daily dose will be limited to 360mg/day. The initial approval period will be for a period of six months. Recipients age 21 or greater diagnosed with hyperlipidemia may be approved for treatment with Xenical® upon physician documentation of medical necessity. An extension of benefits may be granted upon physician documentation of therapy successes.

*Complete all items or the approval request will be returned for additional information
If information not available, please explain.*

This is: _____ **Initial Certification** _____ **Recertification**

Client Name: _____	Medicaid ID#: _____
Address: _____	Date of Birth: _____
_____	Gender: _____
	Phone: _____

Diagnosis:

Total Cholesterol: _____ mg/dl	Date: _____
LDL _____ mg/dl	BMI: _____
HDL _____ mg/dl	Date: _____

PHYSICIAN SECTION MUST BE COMPLETED

Name: _____	Tx. License #: _____
Address: _____	Phone: _____
_____	Fax: _____
_____	Date patient last seen _____

I certify that the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Physician Signature: _____	Date _____
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FORM SUBMITTAL INSTRUCTIONS

JoAnn Foster, R.Ph. Gay Stokes Fax	512-491-1407 512-491-1962	Drug Use Review (H-630) HHSC Medicaid/CHIP Vendor Drug Program PO Box 85200 Austin, Texas 78708-5200
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