FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Anorexiants Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Appetite suppression
❑ Weight loss
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Lifestyle modification:

Is the requested medication being used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community based program)? ❑ **Yes** ❑ **No**

Body Mass Index (BMI):

What is the patient's current BMI? _____kg/m^2

Comorbidities:

Does the patient have a weight-related comorbidity (e.g., hypercholesterolemia, hypertension, diabetes, sleep apnea)? ❑ **Yes** ❑ **No**

For Belviq, Belviq XR, Qsymia, and Saxenda requests, also answer the following:

Has the patient failed to lose greater than or equal to 5% of baseline body weight after at least 16 weeks (one full course) of Contrave therapy? ❑ **Yes** ❑ **No**

Does the patient have an intolerance or contraindication to Contrave therapy? ❑ **Yes** ❑ **No**

Reauthorization:

Has the patient had weight loss of greater than or equal to 5% of baseline body weight? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.