

WEIGHT LOSS PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today's Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis: <input type="checkbox"/> Obesity <input type="checkbox"/> Other (ICD code, plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
For all requests: 1. What is the patient's pretreatment BMI? _____ (kg/m ²) 2. Is the patient currently using the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Does the patient have any FDA labeled contraindications to the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify FDA labeled contraindications: _____ _____ 4. Will the patient be using the requested agent in combination with another weight loss agent (e.g., Contrave, phentermine, Qsymia, Xenical, Saxenda, Wegovy, Zepbound) for the requested indication? <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Has the patient been on a weight loss regimen of a low-calorie diet, increased physical activity, and behavioral modifications for a minimum of 6 months prior to initiating therapy with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Is the patient currently on and will continue a weight loss regimen of a low-calorie diet, increased physical activity, and behavioral modifications? <input type="checkbox"/> Yes <input type="checkbox"/> No 7. Is the patient's age within FDA labeling for the requested indication for the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide support for using the requested agent for the patient's age: _____ _____ 8. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). Please note, documentation may be required: _____ _____ _____	
Please continue to the next page.	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
-----------------------	-------	----	-------------------

For patients 18 years of age or older:

9. Is the patient of South Asian, Southeast Asian, or East Asian descent? Yes No
10. Does the patient have at least one weight-related comorbidity/risk factor/complication (e.g., diabetes, dyslipidemia, coronary artery disease)? Yes No

For patients 12 to 17 years of age:

11. Does the patient have a diagnosis of obesity confirmed by a pretreatment BMI greater than or equal to 95th percentile for age and gender? Yes No
12. Does the patient have a pretreatment BMI greater than or equal to 85th percentile for age and gender AND at least one weight-related comorbidity/risk factor/complication (e.g., hypertension, dyslipidemia, type 2 diabetes, or obstructive sleep apnea)? Yes No

For Contrave requests:

13. Is the patient newly starting therapy with Contrave? Yes No
 If no, is the patient currently being treated and has received less than 16 weeks (4 months) of therapy? Yes No
 If no, has the patient achieved and maintained a weight loss of greater than or equal to 5% from baseline (prior to the initiation of requested agent)? Yes No

For Qsymia requests:

14. If the patient is an adult, has the patient demonstrated and maintained a weight loss of greater than or equal to 5% from baseline (prior to initiation of the requested agent)? Yes No
15. If the patient is pediatric (12 to less than 18 years of age), has the patient experienced a reduction of at least 5% of baseline BMI (prior to initiation of the requested agent)? Yes No
16. Has the patient received less than 14 weeks of therapy? Yes No
17. Is the patient's dose being titrated upward? Yes No
18. Has the patient received less than 12 weeks (3 months) of therapy on the 15 mg/92 mg strength? Yes No
19. If newly starting with a dose greater than 3.75 mg/23 mg, provide support for therapy for the requested dose for this patient: _____

For Xenical (or Orlistat) requests:

20. Is the patient newly starting therapy with Xenical (or Orlistat)? Yes No
 If no, is the patient currently being treated and has received less than 12 weeks (3 months) of therapy? Yes No
 If no and the patient is 17 years of age or older, has the patient achieved and maintained a weight loss of greater than or equal to 5% from baseline (prior to initiation of requested agent) Yes No
 If no and the patient is 12 to 16 years of age, has the patient achieved and maintained a weight loss of greater than 4% from baseline (prior to initiation of requested agent) Yes No

For renewal requests (Patient continuing a current weight loss course of therapy):

21. Is the patient currently on and will continue to be on a weight loss regimen of a low-calorie diet, increased physical activity, and behavioral modifications? Yes No
22. Is the patient pediatric (12 to less than 18 years of age)? Yes No
 If yes, is the current BMI greater than 85th percentile for age and gender? Yes No
23. Has the patient achieved and maintained a weight loss of greater than or equal to 5% from baseline (prior to the initiation of requested agent)? Yes No

For Qsymia renewal requests:

24. If the patient is an adult, has the patient achieved and maintained a weight loss of greater than or equal to 5% from baseline (prior to initiation of the requested agent)? Yes No
25. If the patient is pediatric (12 to less than 18 years of age), has the patient achieved and maintained a reduction of greater than or equal to 5% of baseline BMI (prior to initiation of the requested agent)? Yes No

Please fax or mail this form to:
 Prime Therapeutics LLC
 Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
BCBSIL: 800.285.9426
BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.