WEIGHT LOSS AGENTS
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

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

Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information please visit *www.myprime.com*.

What is the priority level of this request?

☐ Standard

☐ Date of service (if applicable): _____

☐ Urgent (NOTE: Urgent is defined as when the prescriber believes that waiting for a standard review could seriously harm the patient's life, health, or ability to regain maximum function.)

PATIENT AND INSURANCE INFORMATION **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 #:	

RENDERING/SERVICING PRESCRIBER INFORMATION (IF APPLICABLE)

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:

☐ Obesity

☐ Other (ICD code and description): _____

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. Please provide the patient's baseline weight and BMI (prior to initiation of requested agent):
   Baseline weight: _____kg Baseline BMI: _____kg/m^2
2. Is the patient currently treated with the requested agent? ☐ Yes ☐ No
   If yes, when was therapy with the requested agent started? _____
   If yes, has the patient demonstrated and maintained a weight loss from baseline (prior to initiation of the requested agent? ☐ Yes ☐ No
   If yes, please specify the following:
   Current weight: _____ kg Current BMI: _____ kg/m^2 Percent weight loss from baseline: _____%
3. Is the patient newly starting therapy? ☐ Yes ☐ No
   If no, is the patient continuing a current weight loss course of therapy? ☐ Yes ☐ No
4. Has the patient tried a targeted weight loss agent (Adipex-P, phentermine, Benzphetamine, Contrave, Diethylpropion, Lomaira, Phendimetrazine, Qsymia, Saxenda, Wegovy, Xenical, Zepbound) in the past 12 months? ☐ Yes ☐ No
5. Is the patient attempting a repeated weight loss course of therapy? ☐ Yes ☐ No
   If yes, is success anticipated with repeating therapy for the requested indication? ☐ Yes ☐ No

Please continue to the next page.

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

6. 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? ☐ Yes ☐ No
   If yes, is the patient currently on and will continue a weight loss regimen of a low-calorie diet, increased physical activity, and behavioral modifications? ☐ Yes ☐ No
   If no, will the patient initiate a weight loss regimen of a low-calorie diet, increased physical activity, and behavioral modifications along with the requested agent? ☐ Yes ☐ No
7. Will the patient be using the requested agent in combination with another weight loss agent? ☐ Yes ☐ No
8. Did the patient achieve a weight loss of 1 pound or more per week while on a weight loss regimen prior to initiating therapy with the requested agent? ☐ Yes ☐ No
9. Is the patient's age within FDA labeling for the requested indication for the requested agent? ☐ Yes ☐ No
   If no, is there information in support of using the requested agent for the patient's age? ☐ Yes ☐ No
   If yes, please provide supporting information: _____
   _____
10. Does the patient have any FDA labeled contraindications to the requested agent? ☐ Yes ☐ No3
    If yes, please specify FDA labeled contraindication(s):_____
    _____
11. Please list all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). _____
    _____
    _____
12. Please list all medications the patient has previously tried and failed for treatment of this diagnosis. Please specify if the patient has tried brand-name products, generic products or over-the-counter products.

_____	Date(s): _____	_____	Date(s): _____
_____	Date(s): _____	_____	Date(s): _____
_____	Date(s): _____	_____	Date(s): _____

For patients 12 to 16 years of age:

13. Does the patient have a diagnosis of obesity, confirmed by a BMI ≥95th percentile for age and gender? ☐ Yes ☐ No
    If no, does the patient have a diagnosis of obesity, confirmed by a BMI greater than or equal to 30 kg/m^2? ☐ Yes ☐ No
    If no, does the patient have a BMI greater than or equal to the 85th percentile for age and gender AND at least one severe weight-related comorbidity/risk factor/complication? ☐ Yes ☐ No

For patients older than 17 years of age:

14. Is the patient of South Asian, Southeast Asian, or East Asian descent? *This information is requested due to information from the American Association of Clinical Endocrinologists and American College of Endocrinology comprehensive clinical practice guidelines for medical care of patients with obesity. ☐ Yes ☐ No
    If yes, does the patient have a diagnosis of obesity, confirmed by a BMI of ≥ 25kg/m^2? ☐ Yes ☐ No
    If no, does the patient have a diagnosis of obesity, confirmed by a BMI ≥30 kg/m^2? ☐ Yes ☐ No
    If no, does the patient have a BMI of greater than or equal to 27 kg/m^2 with at least one weight-related comorbidity/risk factor/complication (e.g., diabetes, dyslipidemia, coronary artery disease)? ☐ Yes ☐ No

For Contrave requests:

15. Is the patient currently being treated with Contrave and has received less than 16 weeks (4 months) of therapy? ☐ Yes ☐ No

For Saxenda requests:

16. Is Saxenda being used to treat type 2 diabetes? ☐ Yes ☐ No
17. Will the patient be using the requested agent in combination with another GLP-1 receptor agonist agent? ☐ Yes ☐ No
18. Is the patient currently being treated with the requested agent? ☐ Yes ☐ No
    If yes, for patients 18 years of age or older: has the patient received less than 16 weeks of therapy? ☐ Yes ☐ No
    If yes, for patients 12-18 years of age: has the patient received less than 20 weeks of therapy? ☐ Yes ☐ No
19. Has the patient achieved and maintained a reduction in BMI of ≥1% from baseline (prior to initiation of requested agent)? ☐ Yes ☐ No

Please continue to the next page.

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

For Qsymia requests:

20. Is the patient an adult? ☐ Yes ☐ No
    If no, has the patient experienced a reduction of at least 5% of baseline BMI (prior to initiation of the requested agent? ☐ Yes ☐ No
21. Has the patient received fewer than 14 weeks of Qsymia therapy? ☐ Yes ☐ No
22. Is the patient's dose being titrated upward? ☐ Yes ☐ No
23. Has the patient received fewer than 12 weeks of therapy on the 15mg/92mg strength? ☐ Yes ☐ No
24. Is there information in support of therapy for the requested dose for this patient? ☐ Yes ☐ No
    If yes, please provide supporting information: _____
    _____

For Wegovy requests:

25. Will the patient be using the requested agent in combination with another GLP-1 receptor agonist agent? ☐ Yes ☐ No
26. Does the patient have a history of pancreatitis? ☐ Yes ☐ No
27. Is the patient currently being treated with the requested agent? ☐ Yes ☐ No
    If yes, has the patient received less than 52 weeks (1 year) of therapy? ☐ Yes ☐ No
28. Will the patient be using the 0.25mg, 0.5mg, or 1mg pen for maintenance therapy? ☐ Yes ☐ No

For Xenical requests:

29. Is the patient currently being treated with Xenical and has received less than 12 weeks (3 months) of therapy? ☐ Yes ☐ No

For Zepbound requests:

30. Will the patient be using the requested agent in combination with another GLP-1 receptor agonist agent? ☐ Yes ☐ No
31. Does the patient have a history of pancreatitis? ☐ Yes ☐ No
32. Is the patient currently being treated with the requested agent? ☐ Yes ☐ No
    If yes, has the patient received less than 52 weeks (1 year) of therapy? ☐ Yes ☐ No

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

33. Is the patient pediatric (12 to less than 18 years of age)? ☐ Yes ☐ No
    If yes, is the patient's current BMI greater than 85th percentile for age and gender? ☐ Yes ☐ No

For Qsymia requests:

34. Is the patient's dose being titrated upward? ☐ Yes ☐ No
35. Has the patient received less than 12 weeks of therapy on the 15mg/92mg strength? ☐ Yes ☐ No

For Wegovy requests:

36. Has the patient received less than 52 weeks of therapy on the maximum-tolerated dose (1.7 mg or 2.4 mg)? ☐ Yes ☐ No

For Zepbound requests:

37. Has the patient received less than 52 weeks of therapy on the maximum-tolerated dose? ☐ Yes ☐ No

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

TOLL FREE

Phone:	**888.274.5158**	**Fax: 855.212.8110**
BCBSFL:	**888.271.3183**	**Fax: 855.212.8110**
BCBSNJ:	**888.214.1784**	**Fax: 855.212.8110**
BCBSRI:	**855.457.0759**	**Fax: 855.212.8110**
CHP:	**855.457.0754**	**Fax: 855.212.8110**