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 plus 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, has the patient achieved and maintained a weight loss and/or reduction in BMI from baseline? ..... ☐ Yes ☐ No
   If yes, please specify the following:
   Current weight: _____ kg Percentage weight loss from baseline: _____ %
   Current BMI: _____ kg/m^2 Percentage reduction from baseline:_____ %
3. Does the patient have any FDA labeled contraindications to the requested agent? ..... ☐ Yes ☐ No
   If yes, please specify FDA labeled contraindications:_____
   _____
4. Is the requested agent being used for weight loss? ..... ☐ Yes ☐ No
5. 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?..... ☐ Yes ☐ No

Please continue to the next page.

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

6. Is the patient newly starting therapy with the requested agent? ☐ Yes ☐ No
   If no, please select ONE of the following:
   ☐ Attempting repeated weight loss course of therapy ☐ Continuing a current weight loss course of therapy
7. Has the patient tried a targeted weight loss agent (e.g., benzphetamine, Contrave, diethylpropion, phendimetrazine, phentermine, Qsymia, Xenical/Orlistat) in the past 12 months? ☐ Yes ☐ No
   If yes, is success anticipated with repeating therapy with any targeted weight loss agent? ☐ Yes ☐ No
8. 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
9. 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
10. Is the patient's age within FDA labeling for the requested indication for the requested agent? ☐ Yes ☐ No
    If no, is there support for using the requested agent for the patient's age for the requested indication? ☐ Yes ☐ No
    If yes, please provide supporting information: _____
    _____
11. Please list all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, 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 pediatric patients (12 to 17 years of age):

13. Does the patient have a diagnosis of obesity, confirmed by a BMI greater than or equal to the 95th percentile for the patient's 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 weight-related comorbidity/risk factor/complication (e.g., hypertenstion, dyslipidemia, type 2 diabetes, or obstructive sleep apena)? ☐ Yes ☐ No

For adult patients (18 years of age or over):

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 greater than or equal to 25 kg/m^2? ☐ 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
15. 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 (naltrexone/bupropion) requests:

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

For Qsymia (phentermine/topiramate) requests:

17. Has the patient received less than 14 weeks of therapy? ☐ Yes ☐ No
18. Is the patient's dose being titrated upward? ☐ Yes ☐ No
19. Has the patient received less than 12 weeks (3 months) of therapy on the highest strength (i.e.,15 mg/92 mg)? ☐ Yes ☐ No
20. Is there support for therapy for the requested dose for this patient? ☐ Yes ☐ No
    If yes, please provide supporting information: _____
    _____

Please continue to the next page.

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

For Xenical or Orlistat requests:

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

For renewal requests:

For pediatric patients:

22. Is the patient's current BMI greater than the 85th percentile for age and gender? ☐ 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

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BCBSRI:	**855.457.0759**	**Fax: 855.212.8110**
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