HIGHMARK

PRESCRIPTION DRUG
MEDICATION REQUEST FORM
FAX TO 1-866-240-8123

WEIGHT LOSS MEDICATIONS FORM

PATIENT INFORMATION

Subscriber ID Number		Group Number	
Patient Name	Patient Telephone Number		Date of Birth
Patient Address	City	State	Zip Code

MEDICATION INFORMATION

Drug Name	Strength	Requested Quantity **per Month**
Diagnosis		

CLINICAL CRITERIA

Please provide the patient's **baseline** (prior to therapy with the requested medication)

Height: Weight: Body Mass Index:

If the patient has been using this medication, please also provide the patient's **current** (after therapy)

Height: Weight: Body Mass Index:

1. Does the patient have any of the following weight-related comorbidities? *Hypertension, Dyslipidemia, Type 2 diabetes mellitus, Obstructive sleep apnea, Symptomatic arthritis of the lower extremities, Gastroesophageal reflux disease, Coronary artery disease*	Yes	No
2. Will the patient be using the requested medication in combination with a reduced calorie diet and an exercise regimen?	Yes	No
3. Is the patient currently established on therapy with the requested medication? a. If **YES**: Please specify how long the patient has been on therapy: _____	Yes	No
4. If requesting Saxenda or Wegovy: Will the patient be using Saxenda or Wegovy in combination with any GLP-receptor agonists or insulin/GLP-receptor agonist combinations?	Yes	No

5. If requesting Saxenda or Wegovy: Has the patient tried and failed any of the following medications or does the patient have a contraindication? If the patient has a contraindication, please describe.

Medication	**Tried and Failed**	**Contraindication – please describe:**
Contrave	Yes / No	
Qsymia	Yes / No	
Xenical	Yes / No	

MEDICAL RATIONALE / REASON FOR DRUG THERAPY

PRESCRIBER INFORMATION

Physician Name	Phone	Fax
Physician Address	City / State / Zip Code	
Suite / Building	Physician Signature	Date

The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
3. Please provide the physician address as it is required for physician notification.
4. Fax the **completed** form and all clinical documentation to **1-866-240-8123**