

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

WEIGHT LOSS MEDICATIONS FORM PATIENT INFORMATION							
Subscriber ID Number					Group Num	ber	
Patient Name				Patient Telephon	e Number	Date of Birth	
Patient Address				City	State	Zip Cod	e
MEDICATION INFORMATION							
Drug Name				Strength		Requested Quantity <u>per Month</u>	
Diagnosis							
CLINICAL CRITERIA							
Please provide the patient's <b>baseline</b> (prior to therapy with the requested medication)							
Height:			Weight:		Body Mass Ind	lex:	
If the patient has been using this medication, please also provide the patient's <b>current</b> (after therapy)							
Height: Weight:				Body Mass Index:			
1. Does the patient	have any c	of the follow	ving weight-relate	ed comorbiditi	es?		
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?						ie Yes	No
<ul> <li>3. Is the patient currently established on therapy with the requested medication?</li> <li>a. If YES:</li> <li>Please specify how long the patient has been on therapy:</li> </ul>						Yes	No
<ol> <li>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?</li> </ol>						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 an				•		
Contrave	Yes						
Qsymia Xenical	Yes Yes						
Kenioai	100	/ 110					
MEDICAL RATIONALE / REASON FOR DRUG THERAPY							
PRESCRIBER INFORMATION							
Physician Name				Phone		Fax	
Physician Address				City	State	Zip Cod	e
Suite / Building		Physician Sig	Inature			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 <u>ALL</u> 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 <u>completed</u> form and all clinical documentation to 1-866-240-8123

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