

**WEIGHT LOSS MEDICATIONS FORM**
**MEMBER INFORMATION**

Subscriber's ID Number		Subscriber's Group Number	
Member's Name		Phone	Date of Birth
Address	City	State	Zip Code

**PRESCRIBER INFORMATION**

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

**MEDICATION INFORMATION**

Drug Name	Strength	Requested Quantity <u>per Month</u>
Diagnosis		

**CLINICAL CRITERIA**

1. Will the member be using the requested medication in combination with a reduced calorie diet and an exercise regimen?	Yes	No
2. Does the member have any of the following weight-related comorbidities? <i>Hypertension, Dyslipidemia, Type 2 diabetes mellitus, Obstructive sleep apnea, Symptomatic arthritis of the lower extremities, Gastroesophageal reflux disease, Coronary artery disease</i>	Yes	No
3. Does the prescriber attest to the following: the member has had active participation for at least 3 months in a lifestyle modification program that encourages reduced calorie diet and increased physical activity (e.g., increased physical activity, nutritional counseling, participation in a comprehensive weight management program) prior to initiation of the requested medication?	Yes	No
4. Please provide the member's <b>baseline</b> (prior to therapy with the requested medication): Height: _____ Weight: _____ Body Mass Index: _____		
5. If the member is currently on therapy with the requested medication:		
a. Please specify how long the member has been on therapy: _____		
b. Please provide the member's <b>current</b> (while on therapy with the requested medication): Height: _____ Weight: _____ Body Mass Index: _____		
c. Does the prescriber attest to the following: the member is using the requested medication in combination with a lifestyle modification program that encourages reduced calorie diet and increased physical activity (e.g., increased physical activity, nutritional counseling, participation in a comprehensive weight management program)?	Yes	No

<p>6. If this request is for a glucagon-like peptide-1 receptor agonist (e.g. Saxenda, Wegovy, Zepbound, etc.):</p> <p>Will the member be using the requested medication in combination with a GLP-1 RA (glucagon-like peptide-1 receptor agonist) or GLP-1 RA combinations (e.g. Ozempic, Soliqua, etc.)?</p>	<p>Yes</p>	<p>No</p>
<p>7. Please provide any other medications previously tried and failed for the member's diagnosis:</p> <hr/> <hr/>		

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 member. 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. Please print, type or write legibly in blue or black ink.
3. Complete **ALL** information on the form.  
**NOTE:** *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
4. Please provide the physician address as it is required for physician notification.
5. Fax the **completed** form and all clinical documentation to **1-866-240-8123**  
Or mail the form to: **Clinical Services,  
120 Fifth Avenue, MC PAPHM-043B, Pittsburgh, PA 15222**

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