OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Anorexiants Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Appetite suppression
❑ Weight loss
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Lifestyle modification:

Is the requested medication being used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community based program)? ❑ **Yes** ❑ **No**

Body Mass Index (BMI):

What is the patient's current BMI? _____kg/m^2

Comorbidities:

Does the patient have a weight-related comorbidity (e.g., hypercholesterolemia, hypertension, diabetes, sleep apnea)? ❑ **Yes** ❑ **No**

For Belviq, Belviq XR, Qsymia, and Saxenda requests, also answer the following:

Has the patient failed to lose greater than or equal to 5% of baseline body weight after at least 16 weeks (one full course) of Contrave therapy? ❑ **Yes** ❑ **No**

Does the patient have an intolerance or contraindication to Contrave therapy? ❑ **Yes** ❑ **No**

Reauthorization:

Has the patient had weight loss of greater than or equal to 5% of baseline body weight? ❑ **Yes** ❑ **No**

Is the patient continuing to practice lifestyle modification? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.