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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Anorexiant Prior Authorization Request Form

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

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information <small>(required)</small>			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information <small>(required)</small>
<p>Select the diagnosis below:</p> <p><input type="checkbox"/> Appetite suppression</p> <p><input type="checkbox"/> Weight loss</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>
<p>Lifestyle modification:</p> <p>Is the requested medication being used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community based program)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Body Mass Index (BMI):</p> <p>What is the patient's current BMI? _____ kg/m²</p> <p>Comorbidities:</p> <p>Does the patient have a weight-related comorbidity (e.g., hypercholesterolemia, hypertension, diabetes, sleep apnea)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>For Belviq, Belviq XR, Qsymia, and Saxenda requests, also answer the following:</p> <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have an intolerance or contraindication to Contrave therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Reauthorization:</p> <p>Has the patient had weight loss of greater than or equal to 5% of baseline body weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient continuing to practice lifestyle modification? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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.

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