

FORWARDHEALTH
PRIOR AUTHORIZATION DRUG ATTACHMENT FOR ANTI-OBESITY DRUGS

Instructions: Type or print clearly. Before completing this form, read Prior Authorization Drug Attachment for Anti-Obesity Drugs Completion Instructions, F-00163I.

Providers may call the Drug Authorization and Policy Override Center at (800) 947-9627 with questions.

SECTION I — MEMBER AND PROVIDER INFORMATION

1. Name — Member (Last, First, Middle Initial)	
2. Member Identification Number	3. Date of Birth — Member
4. Name — Prescriber	5. National Provider Identifier (NPI) — Prescriber
6. Address — Prescriber (Street, City, State, ZIP+4 Code)	7. Telephone Number — Prescriber
8. Name — Billing Provider	9. NPI — Billing Provider

SECTION II — PRESCRIPTION INFORMATION

10. Drug Name (Check only one.) <input type="checkbox"/> Xenical® (orlistat) <input type="checkbox"/> Meridia® (sibutramine) <input type="checkbox"/> diethylpropion <input type="checkbox"/> phentermine <input type="checkbox"/> phendimetrazine	
11. Drug Strength	12. Date Prescription Written
13. Directions for Use	14. Refills

SECTION III — CLINICAL INFORMATION

15. Diagnosis Code and Description	
16. Height — Member (Inches)	17. Weight — Member (Pounds)
18. Date Member's Weight Was Measured	19. Body Mass Index (BMI) — Member (lb / in ²)
20. Goal Weight — Member (Pounds)	BMI = $\frac{703 \times (\text{weight in pounds})}{(\text{height in inches})^2}$

For an initial drug request, the provider should complete Section IV A and Section IV B. For a renewal drug request, the provider should complete Section IV A.

SECTION IV A — INITIAL AND RENEWAL COVERAGE REQUIREMENTS

21. Is the member pregnant or nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
22. Does the member have a history of an eating disorder (e.g., anorexia, bulimia)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Continued



SECTION IV A — INITIAL AND RENEWAL COVERAGE REQUIREMENTS (Continued)

23. Medication Contraindications (Check either A, B, or C and answer the questions that follow.)

- A. Xenical® (orlistat)
- Does the member have chronic malabsorption syndrome? Yes No
 - Does the member have cholestasis? Yes No
- B. Meridia® (sibutramine)
- Has the member taken any monoamine oxidase inhibitors (MAOIs) within the past 14 days? Yes No
 - Is the member taking any other centrally acting weight loss drugs? Yes No
- C. Phendimetrazine, phentermine, or diethylpropion
- Does the member have glaucoma? Yes No
 - Does the member have hyperthyroidism? Yes No
 - Does the member have advanced arteriosclerosis? Yes No
 - Does the member have a history of drug abuse or misuse? Yes No
 - Does the member have uncontrolled hypertension? Yes No
 - Is the member hypersensitive to any sympathomimetic amines? Yes No
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SECTION IV B — INITIAL COVERAGE REQUIREMENTS

24. Body Mass Index Requirements (Check A or B.)

- A. The member's BMI is greater than or equal to 30.
- B. The member's BMI is greater than or equal to 27 but less than 30 with two or more of the following risk factors.
Check the member's current risk factors.
- Coronary Heart Disease.
 - Dyslipidemia.
 - Hypertension.
 - Sleep Apnea.
 - Type II Diabetes Mellitus.
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25. Has the member participated in a weight loss treatment plan (e.g., nutritional counseling, an exercise regimen, a calorie-restricted diet) in the past six months and will member continue to follow this treatment plan while taking an anti-obesity drug? Yes No

If yes, describe the treatment plan in the space provided.

SECTION V — AUTHORIZED SIGNATURE

26. SIGNATURE — Prescriber

27. Date Signed — Prescriber

SECTION VI — ADDITIONAL INFORMATION

28. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

SECTION VII — FOR INTERNAL USE ONLY

- Initial request.
 - Renewal request (Meridia® or Xenical®).
 - Renewal request (diethylpropion, phendimetrazine, or phentermine).
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