

Weight-Loss Agents
Choice Prior Authorization Request Prescriber Fax
Fax this form to 800-424-3260

Prime Therapeutics Management LLC partners with CoverMyMeds to allow for the submission of electronic PA requests. **For faster coverage determinations, go to www.CoverMyMeds.com.**

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews. Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information visit primetherapeutics.com/commercial-formularies.

What is the priority level of this request?

- Standard
- Date of service (if applicable): _____
- Urgent (**Note:** Urgent is defined as when the prescriber believes that waiting for a standard review could seriously harm the patient's life, health, or ability to regain maximum function.)

Today's Date: _____

PATIENT INFORMATION

Patient Last Name: _____

Patient First Name: _____

Patient ID: _____ Date of Birth: _____ Patient Phone: _____

Patient Street Address: _____

City: _____ State: _____ Zip: _____

Sex: Male Female Height: _____ in. cm Weight: _____ lbs. kg

Allergies: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Specialty: _____ Email: _____

Prescriber NPI: _____ DEA: _____

Prescriber Phone: _____ Prescriber Fax: _____

Prescriber Street Address: _____

City: _____ State: _____ Zip: _____

Patient's Name (Last, First): _____

DRUG INFORMATION

Drug Name: _____ Drug Form: _____

Drug Strength: _____ Dosing Frequency: _____

Length of Therapy: _____ Quantity: _____

Number of Refills: _____ Day Supply: _____

New Therapy Renewal If renewal, date therapy initiated: _____

If renewal, duration of therapy (specific dates): _____ to _____

CRITERIA FOR ALL REQUESTS

Note: Please attach any additional information that should be considered with this request.

Patient's Diagnosis:

Obesity

Other (ICD Code and Description below):

ICD Code: _____

ICD Description: _____

1. What is the patient's **baseline** weight and body mass index (BMI) prior to initiation of requested agent?

Baseline Weight: _____ kg Baseline BMI: _____ kg/m²

2. Is the requested agent being used for weight loss?

Yes No

3. Is the patient currently treated with the requested agent?

Yes No

If Yes, when was therapy with the requested agent started?

If Yes, has the patient demonstrated and maintained a weight loss from baseline?

Yes No

If Yes, please specify the following:

Current Weight: _____ kg Current BMI: _____ kg/m²

Percent weight loss from baseline: _____ %

4. Is the patient newly starting therapy with the requested agent?

Yes No

If No, please select **one** of the following:

The patient is attempting repeated weight loss course of therapy

The patient is continuing a current weight loss course of therapy

Patient's Name (Last, First): _____

5. Has the patient tried a targeted weight-loss agent (e.g., Adipex-P, phentermine, Benzphetamine, Contrave, Diethylpropion, Lomaira, Phendimetrazine, Qsymia, Saxenda, Wegovy, Xenical [orlistat]) in the past 12 months?

Yes No

6. Is the patient attempting a repeated weight loss course of therapy?

Yes No

If Yes, is success anticipated with repeating therapy for the requested indication?

Yes No

7. Has the patient been on a weight-loss regimen of a low-calorie diet, increased physical activity, and behavioral modifications for a minimum of 6 months prior to initiating therapy with the requested agent?

Yes No

If Yes, is the patient currently on and will continue a weight-loss regimen of a low-calorie diet, increased physical activity, and behavioral modifications?

Yes No

8. Will the patient be using the requested agent in combination with another weight-loss agent (e.g., Contrave, phentermine, Qsymia, Xenical, Saxenda, Wegovy, Zepbound)?

Yes No

9. Is the patient's age within FDA labeling for the requested indication for the requested agent?

Yes No

If No, is there information in support of using the requested agent for the patient's age?

Yes No

If Yes, please explain:

10. Does the patient have any FDA-labeled contraindications to the requested agent?

Yes No

If Yes, please specify contraindication(s):

11. Please list all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, or history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max).

Patient's Name (Last, First): _____

12. Please list all medications that the patient has previously tried and failed for treatment of this diagnosis. Please specify whether the patient has tried brand-name products, generic products, or over-the-counter products.

Medication: _____ Type: _____

Date (from): _____ Date (to): _____

Medication: _____ Type: _____

Date (from): _____ Date (to): _____

Medication: _____ Type: _____

Date (from): _____ Date (to): _____

CRITERIA FOR PATIENTS 12 TO 17 YEARS OF AGE

13. Does the patient have a diagnosis of obesity, confirmed by a BMI greater than or equal to the 95th percentile for age and gender?

Yes No

If No, does the patient have a diagnosis of obesity, confirmed by a BMI greater than or equal to 30 kg/m²?

Yes No

If No, does the patient have a BMI greater than or equal to the 85th percentile for age and gender and at least one severe weight-related comorbidity/risk factor/complication?

Yes No

CRITERIA FOR PATIENTS OLDER THAN 17 YEARS OF AGE

14. Is the patient of South Asian, Southeast Asian, or East Asian descent?

*This information is requested due to information from the American Association of Clinical Endocrinologists and American College of Endocrinology comprehensive clinical practice guidelines for medical care of patients with obesity.

Yes No

If Yes, does the patient have a diagnosis of obesity, confirmed by a BMI of at least 25kg/m²?

Yes No

If No, does the patient have a diagnosis of obesity, confirmed by a BMI of at least 30 kg/m²?

Yes No

If No, does the patient have a BMI of at least 27 kg/m² with at least one weight-related comorbidity/risk factor/complication?

Yes No

Patient's Name (Last, First): _____

CRITERIA FOR CONTRAVE

15. Is the patient currently being treated and has received less than 16 weeks (4 months) of therapy?
 Yes No

CRITERIA FOR QSYMIA

16. Has the patient received fewer than 14 weeks of Qsymia therapy?
 Yes No
17. Is the patient's dose being titrated upward?
 Yes No
18. Has the patient received fewer than 12 weeks of therapy on the 15 mg/92 mg strength?
 Yes No
19. Is there information in support of therapy for the requested dose for this patient?
 Yes No

If Yes, please explain:

CRITERIA FOR XENICAL OR ORLISTAT REQUESTS

20. Is the patient currently being treated and has received less than 12 weeks (3 months) of therapy?
 Yes No

RENEWAL CRITERIA FOR PEDIATRIC PATIENTS

21. Is the patient's current BMI greater than the 85th percentile for age and gender?
 Yes No

Attachments

Patient's Name (Last, First): _____

ATTESTATION

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group, or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber's Signature: _____ **Date:** _____

(By signature, the physician confirms the above information is accurate and verifiable by patient records.)

Please fax or mail this form to:

Prime Therapeutics Management LLC

Attn: CP – 4201

P.O. Box 64811

St. Paul, MN 55164-0811

Phone: 1-800-424-3312

Fax this form to 800-424-3260

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