PRO ACT
PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Anorexiants Prior Authorization Request Form (Page 1 of 2)

Member Information (required)			Provider Information (required)		
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 (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**

Medication history:
Is the requested medication being used in combination with another anti-obesity agent? ❑ **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**
Is the requested medication being used in combination with another anti-obesity agent? ❑ **Yes** ❑ **No**

Quantity limit requests:
What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?
❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Anorexiants Prior Authorization Request Form (Page 2 of 2)

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.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	