Prior Authorization Form

CVS-CAREMARK FAX FORM

Phentermine/Phendimetrazine/Didrex/Diethylpropion

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 18888360730.
Please contact CVS|Caremark at 18884143125 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Phentermine/Phendimetrazine/Didrex/Diethylpropion.

Drug Name(specify drug) _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each applicable question.

1. Is the patient 16 years of age or older? Y N
   [If the answer to this question is no, then no further questions required.]
2. Does the patient have poorly controlled or uncontrolled hypertension? Y N
   [If the answer to this question is yes, then no further questions required.]
3. Does the patient have symptomatic cardiovascular disease and/or advanced atherosclerosis? Y N
   [If the answer to this question is yes, then no further questions required.]
4. Does the patient have hyperthyroidism? Y N
   [If the answer to this question is yes, then no further questions required.]
5. Does the patient have glaucoma? Y N
   [If the answer to this question is yes, then no further questions required.]
6. Does the patient have a history of drug abuse? Y N
   [If the answer to this question is yes, then no further questions required.]
7. Has the patient had monoamine oxidase inhibitor therapy within the last 14 days? Y N
   [If the answer to this question is yes, then no further questions required.]
8. Will the patient have his/her blood pressure and heart rate monitored while on anorectic therapy? Y N
9. Has the patient taken any anorectic therapy under the CVS Caremark prescription benefit in the previous 30 days? Y N

[If the answer to this question is no, then skip to question 12.]

10.	Has the patient lost greater than or equal to one pound per week (4 pounds) since the initiation of therapy?	Y	N
11.	Has the patient received 3 months of anorectic therapy?	Y	N
	[No further questions required]		
12.	Does the patient have a body mass index (BMI) greater than or equal to 30 kg/m2?	Y	N
	[If the answer to this question is yes, then skip to question 15.]		
13.	Does the patient have a body mass index (BMI) greater than or equal to 27 kg/m2?	Y	N
14.	Does the patient have additional risk factors (e.g., diabetes, dyslipidemia, hypertension, sleep apnea, coronary artery disease)?	Y	N
15.	Has the patient been on a regimen of a low-calorie diet, increased physical activity, and behavior therapy for a minimum of 6 months?	Y	N
16.	Did the patient lose at least one pound per week while on the weight-loss regimen?	Y	N
17.	Will the patient continue in an active weight-loss program consisting of low-calorie diet, increased physical activity, and behavioral therapy?	Y	N
18.	Is the patient currently taking other centrally acting drug products for weight loss?	Y	N
	[If the answer to this question is no, then no further questions.]		
19.	Will the patient discontinue these drug products for weight loss?	Y	N

Comments: _____

I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature and Date