



Weight Loss Agents:

Xenical® & Alli® (orlistat), Belviq® (lorcaserin), Adipex-P® (phentermine) & Qsymia® (phentermine/topiramate)

Prior Authorization Request Form

Beneficiary Information

Name:
Medicaid ID #: Date of Birth:

Billing Provider Information (Pharmacy, Physician, or Facility)

Name: Medicaid ID #:
NPI #: Phone #: Fax #:
Requested Drug: NDC:
Dose/day: #Days ordered:

Prescriber Information

Name: Medicaid ID #:
NPI #: Phone #: Fax #:

Requested Information (Required for Initial Requests)

- 1. Provide required measurements taken within last 14 days: Date of Measurements:
Weight: Height: Waist: BMI: Percentile:
2. Indicate if the patient has any of the following comorbidity:
Hypertension Cardiovascular Disease Diabetes Dyslipidemia
Cardiac Arrhythmia in past 12 months Cholestasis in past 12 months
Chronic Intestinal Malabsorption in past 12 months Uncontrolled Hypertension in past 12 months
Unstable Cardiovascular Disease in past 12 months
3. Is the patient pregnant or breast-feeding? Yes No
4. Does the treatment plan include a nutritionally balanced, reduced-calorie diet, exercise and behavioral counseling? Yes No
5. Has the patient taken a Monamine Oxidase Inhibitor (MAOI) in past 14 days? Yes No
6. Has the patient taken phentermine in past 12 months? Yes No
7. Is the patient using Xenical® to reduce the risk of weight regain after prior weight loss? Yes No
Date of Initial BMI: Initial BMI: Comorbid history:

Requested Information (Required for Renewal Requests)

Current Weight: Waist: BMI: % pretreatment weight loss:
Has patient maintained their weight loss? Yes No

Prescriber's Signature: Date:

The completed form should be faxed to the HP Prior Authorization Unit at 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.