Prior Authorization Request Form for **benzphetamine, diethylpropion, phendimetrazine IR and SR, phentermine (Anti Obesity Agents)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is this request for continuation of therapy?	☐ Yes **Proceed to question 11**	☐ No **Proceed to question 2**
2. Is the patient GREATER THAN or EQUAL to 18 years of age?	☐ Yes **Proceed to question 3**	☐ No **STOP Coverage not approved**
3. Does the patient have a history of cardiovascular disease (e.g., arrhythmias, coronary artery disease, heart failure, stroke, uncontrolled hypertension), hyperthyroidism, or other significant contraindication to benzphetamine, diethylpropion, phendimetrazine IR and SR or phentermine?	☐ Yes **STOP Coverage not approved**	☐ No **Proceed to question 4**
4. Does the patient have BMI GREATER THAN or EQUAL to 30, or a BMI GREATER THAN or EQUAL to 27 for those with risk factors in addition to obesity (diabetes, impaired glucose tolerance, dyslipidemia, hypertension, sleep apnea)?	☐ Yes **Proceed to question 5**	☐ No **STOP Coverage not approved**
5. Has the patient engaged in a trial of behavioral modification and dietary restriction for at least 6 months and failed to achieve the desired weight loss, and will remain engaged throughout course of therapy?	☐ Yes **Proceed to question 6**	☐ No **STOP Coverage not approved**
6. Is the patient an Active Duty Service Member?	☐ Yes **Proceed to question 7**	☐ No **Proceed to question 8**

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7. Is the individual enrolled in a Service-specific Health/Wellness Program AND adhere to Service policy, AND will remain engaged throughout course of therapy?	☐ Yes **Proceed to question 8**	☐ No **STOP** **Coverage not approved**
8. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 9**
9. Does the patient have impaired glucose tolerance or diabetes?	☐ Yes **Proceed to question 10**	☐ No **Sign and date below**
10. Has the patient tried metformin first, or is concurrently taking metformin?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
11. Is the patient currently engaged in behavioral modification and on a reduced calorie diet?	☐ Yes **Proceed to question 12**	☐ No **STOP** **Coverage not approved**
12. Has the patient lost GREATER THAN or EQUAL to 5 percent of baseline body weight since starting medication?	☐ Yes **Proceed to question 13**	☐ No **STOP** **Coverage not approved**
13. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 14**
14. Is the patient an Active Duty Service Member?	☐ Yes **Proceed to question 15**	☐ No **Sign and date below**
15. Does the individual continue to be enrolled in a Service-specific Health/Wellness Program AND adheres to Service policy, AND will remain engaged throughout course of therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[21 November 2018]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: