Prior Authorization Request Form for
naltrexone SR/ bupropion SR (Contrave)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

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. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Contrave*	☐ Yes (subject to verification) Proceed to question **15**	☐ 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. Has the patient tried and failed generic phentermine?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Has the patient tried and failed to achieve a 5 percent reduction in baseline weight after a 12 week course of phentermine?	☐ Yes Proceed to question **6**	☐ No **Proceed to question 5**
5. Does the patient have a history of cardiovascular disease (e.g. arrhythmias, coronary artery disease, heart failure, stroke, uncontrolled Hypertension), hyperthyroidism, or significant contraindication to phentermine?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the patient on concurrent opioid therapy, have a seizure disorder, or have uncontrolled hypertension?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **7**

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7. Is the patient currently on a monoamine oxidase inhibitor (e.g., Emsam, Marplan, Nardil), or another formulation of bupropion or naltrexone?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **8**
8. 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 **9**	☐ No **STOP** **Coverage not approved**
9. Has the patient engaged in a trial of behavioral modification and dietary restriction for at least 6 months and has failed to achieve the desired weight loss, and will remain engaged throughout course of therapy?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Is the patient an Active Duty Service Member?	☐ Yes Proceed to question **11**	☐ No Proceed to question **12**
11. 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 **12**	☐ No **STOP** **Coverage not approved**
12. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **13**
13. Does the patient have impaired glucose tolerance or diabetes?	☐ Yes Proceed to question **14**	☐ No **Sign and date below**
14. Has the patient tried metformin first, or is concurrently taking metformin?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
15. Is the patient currently engaged in behavioral modification and on a reduced calorie diet?	☐ Yes Proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. Has the patient lost GREATER THAN or EQUAL to 5 percent of baseline body weight since starting medication?	☐ Yes Proceed to question **17**	☐ No **STOP** **Coverage not approved**
17. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **18**

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18. Is the patient an Active Duty Service Member?	☐ Yes Proceed to question **19**	☐ No **Sign and date below**
19. 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

[28 August 2019]

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