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

JOHNS HOPKINS
HEALTH PLANS
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.

Initial therapy approves for 12 months; annual renewal required.

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 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 BMI GREATER THAN or EQUAL to 30, or a BMI GREATER THAN or EQUAL to 27 in the presence of at least one weight-related comorbidity (diabetes, impaired glucose tolerance, dyslipidemia, hypertension, sleep apnea)?	☐ Yes **Proceed to question 4**	☐ No **STOP Coverage not approved**
4. 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 5**	☐ No **STOP Coverage not approved**
5. Has the patient tried and failed to achieve a 5 percent reduction in baseline weight after a 12 week course of phentermine, benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR?	☐ Yes **Proceed to question 8**	☐ No **Proceed to question 6**

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6. Does the patient have a contraindication to generic phentermine, benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR (for example, arrhythmias, coronary artery disease, heart failure, stroke, uncontrolled hypertension, hyperthyroidism, etc.)?	☐ Yes **Proceed to question 8**	☐ No **Proceed to question 7**
7. Has the patient experienced an adverse reaction to phentermine, benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR that is not expected to occur with Contrave?	☐ Yes **Proceed to question 8**	☐ No **STOP** **Coverage not approved**
8. Is the patient on concurrent opioid therapy, or does the patient have a seizure disorder?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 9**
9. Is the patient currently on a monoamine oxidase inhibitor (for example, Emsam, Marplan, Nardil), or another formulation of bupropion or naltrexone?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 10**
10. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
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 **Sign and date below**

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

_____ _____

Prescriber Signature Date

[28 August 2024]

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