TRICARE Prior Authorization Request Form for
phentermine/topiramate ER (Qsymia)

JOHNS HOPKINS
HEALTH PLANS

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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.

Initial therapy approves for 12 months, and annual renewal is required. For renewal of therapy an initial Tricare prior authorization approval is 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:**

Question		
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 Qsymia.*	☐ Yes (subject to verification) Proceed to question **13**	☐ No Proceed to question **2**
2. How old is the patient?	☐ Less than 12 years of age - **STOP Coverage not approved** ☐ Greater than or equal to 12 years of age and less than 18 years of age - Proceed to question **3** ☐ Greater than or equal to 18 years of age - Proceed to question **6**	
3. Does the patient have a BMI GREATER THAN OR EQUAL TO the 95th percentile standardized for age and sex?	☐ 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. Does the provider agree to monitor the rate of weight loss in pediatric patients? Note: If weight loss exceeds 2 pounds (0.9kg)/week, consider dosage reduction.	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**

Question	Yes	No
6. 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 (for example, diabetes, impaired glucose tolerance, dyslipidemia, hypertension, sleep apnea, etc.)?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. 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 **8**	☐ No **STOP** **Coverage not approved**
8. 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 **11**	☐ No Proceed to question **9**
9. 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 **11**	☐ No Proceed to question **10**
10. Has the patient experienced an adverse reaction to phentermine, benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR that is not expected to occur with Qsymia?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. Will the prescriber abide by and has the patient been informed of the REMS and the following safety concerns associated with this medication: Use in combination with other products intended for weight loss has not been established, Use in patients with increased cardiovascular risk has not been established, Qsymia is pregnancy category X and is associated with increased risk of teratogenicity?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
13. Is the patient currently engaged in behavioral modification and on a reduced calorie diet?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Has the patient lost GREATER THAN or EQUAL to 5 percent of baseline body weight for adult patients or 5 percent of baseline BMI for patients greater than or equal to 12 years of age and less than 18 years of age since starting medication?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. 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 _______________

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