TRICARE Prior Authorization Request Form for
**orlistat (Xenical)**

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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. 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 Xenical.* | ☐ Yes (subject to verification) **Proceed to question 17** | ☐ No **Proceed to question 2** |
| 2. **What is the patient's age?** | ☐ younger than 12 years of age **– STOP Coverage not approved**<br>☐ 12 to 17 years of age **– proceed to question 10**<br>☐ 18 years of age and older **- Proceed to question 3** | |
| 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** |

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| **5. Does the patient have a contraindication to all of the following weight loss medications; generic phentermine, Qsymia, Contrave, Wegovy, and Zepbound?** | ☐ Yes<br>**Proceed to question 7** | ☐ No<br>**Proceed to question 6** |
| **6. Has the patient tried and failed ALL of the following: generic phentermine, Qsymia, Contrave, Wegovy, and Zepbound?** | ☐ Yes<br>**Proceed to question 7** | ☐ No<br>**Proceed to question 8** |

**7. Please provide the date of use and duration of therapy or contraindication for each drug.**

**Phentermine:**

Date_____ Duration of therapy _____

Contraindication: _____

**Qsymia** (or one of its individual generic components phentermine or topiramate)**:**

Date_____ Duration of therapy _____

Contraindication: _____

**Contrave** (or one of its individual generic components bupropion or naltrexone)**:**

Date_____ Duration of therapy _____

Contraindication: _____

**Wegovy:**

Date_____ Duration of therapy _____

Contraindication: _____

**Zepbound:**

Date_____ Duration of therapy _____

Contraindication: _____

**Proceed to question 9**

| | | |
|---|---|---|
| **8. Has the patient experienced an adverse reaction to all of the following weight loss medications; generic phentermine, Qsymia, Contrave, Wegovy, and Zepbound?** | ☐ Yes<br>**Proceed to question 9** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **9. Does the patient have chronic malabsorption syndrome or cholestasis?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>**Proceed to question 16** |

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| **10. Does the patient currently have a BMI of GREATER THAN or EQUAL to the 95th percentile for age and sex, OR if in GREATER THAN or EQUAL to the 85th percentile but LESS THAN 95th percentile for age and sex and has at least one severe co-morbidity (type 2 diabetes mellitus, premature cardiovascular disease) or has a strong family history of diabetes or premature cardiovascular disease (CVD)?** | ☐ Yes<br>**Proceed to question 11** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **11. Has the patient engaged in a trial of behavioral modification and dietary restriction for at least 3 months and has failed to achieve the desired weight loss, and will remain engaged throughout course of therapy?** | ☐ Yes<br>**Proceed to question 12** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **12. Does the patient have a contraindication to Qsymia and Wegovy?** | ☐ Yes<br>**Proceed to question 14** | ☐ No<br>**Proceed to question 13** |
| **13. Has the patient tried and failed Qsymia and Wegovy?** | ☐ Yes<br>**Proceed to question 14** | ☐ No<br>**Proceed to question 15** |

**14. Please provide the date of use and duration of therapy or contraindication for each drug.**

**Qsymia** (or one of its individual generic components, phentermine or topiramate):

Date_____ Duration of therapy _____

Contraindication: _____

**Wegovy:**

Date_____ Duration of therapy _____

Contraindication: _____

**Proceed to question 16**

| | | |
|---|---|---|
| **15. Has the patient experienced an adverse reaction to Qsymia and Wegovy?** | ☐ Yes<br>**Proceed to question 16** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **16. Is the patient pregnant?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>**Sign and date below** |
| **17. Is the patient currently engaged in behavioral modification and on a reduced calorie diet?** | ☐ Yes<br>**Proceed to question 18** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **18. What is the patient's age?** | ☐ younger than 12 years of age **– STOP Coverage not approved**<br>☐ 12 to 17 years of age **– proceed to question 20**<br>☐ 18 years of age and older **- Proceed to question 19** | |

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| **19. Has the patient lost GREATER THAN or EQUAL to 5 percent of baseline body weight since starting medication?** | ☐ Yes<br>**Proceed to question 22** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **20. Has the patient's current BMI percentile decreased for age and weight (considering the patient is increasing in height and will have a different normative BMI from when Xenical was started)?** | ☐ Yes<br>**Proceed to question 22** | ☐ No<br>**Proceed to question 21** |
| **21. Does the patient currently have a BMI GREATER THAN the 85th percentile?** | ☐ Yes<br>**Proceed to question 22** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **22. Is the patient pregnant?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>**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: |