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

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

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

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 Qsymia*	☐ Yes (subject to verification) Proceed to question **14**	☐ 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 **5**	☐ No **STOP** **Coverage not approved**
5. 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 the requested agent?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **6**
6. 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 **7**	☐ No **STOP** **Coverage not approved**

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7. Has the patient has 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. Is the patient an Active Duty Service Member?	☐ Yes Proceed to question **9**	☐ No Proceed to question **10**
9. 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 **10**	☐ No **STOP** **Coverage not approved**
10. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **11**
11. Will the prescriber abide by and has the patient been informed of the REMS and the following safety concerns associated 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 Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Does the patient have impaired glucose tolerance or diabetes?	☐ Yes Proceed to question **13**	☐ No **Sign and date below**
13. Has the patient tried metformin first, or is concurrently taking metformin?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
14. Is the patient currently engaged in behavioral modification and on a reduced calorie diet?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Has the patient lost GREATER THAN or EQUAL to 5 percent of baseline body weight since starting medication?	☐ Yes Proceed to question **19**	☐ No **Proceed to question 16**
16. Is the patient currently receiving Qysmia at a dose of 7.5 mg / 46 mg daily?	☐ Yes Proceed to question **17**	☐ No **STOP** **Coverage not approved**
17. Has the patient lost GREATER THAN or EQUAL to 3 percent of baseline body weight since starting medication?	☐ Yes Proceed to question **18**	☐ No **STOP** **Coverage not approved**
18. Will the dose of Qsymia be escalated to 15 mg/ 92 mg?	☐ Yes Proceed to question **19**	☐ No **STOP** **Coverage not approved**

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19. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **20**
20. Is the patient an Active Duty Service Member?	☐ Yes Proceed to question **21**	☐ No **Sign and date below**
21. 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: