

Prior Authorization Request Form for
liraglutide 3 mg injection (Saxenda)



JOHNS HOPKINS
 HEALTHCARE

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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.

Step 1 Please complete patient and physician information (please print):

1 Patient Name: _____ Physician Name: _____
 Address: _____ Address: _____
 Sponsor ID # _____ Phone #: _____
 Date of Birth: _____ Secure Fax #: _____

Step 2 Please complete the clinical assessment:

<p>2</p> <p>1. Has the patient received this medication under the TRICARE benefit in the last 6 months? <i>Please choose "No" if the patient did not previously have a TRICARE approved PA for Saxenda</i></p>	<input type="checkbox"/> Yes (subject to verification) Proceed to question 14	<input type="checkbox"/> No Proceed to question 2	
	<p>2. Is the patient GREATER THAN or EQUAL to 18 years of age?</p>	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
	<p>3. Has the patient tried and failed or has a contraindication to ALL of the following agents: generic phentermine, Qsymia, Xenical, Contrave, and Belviq or Belviq XR?</p>	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
<p>4. Please provide the date and duration for each medication listed below.</p> <p>Phentermine: Date _____ Duration of therapy _____ Qsymia: Date _____ Duration of therapy _____ Xenical: Date _____ Duration of therapy _____ Contrave: Date _____ Duration of therapy _____ Belviq/Belviq XR: Date _____ Duration of therapy _____</p> <p style="text-align: center;">Proceed to question 5</p>			
<p>5. Is the patient diabetic?</p>	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No Proceed to question 7	

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<p>6. Has the patient tried and failed metformin and the preferred GLP1-RAs (Bydureon and Trulicity)?</p>	<p><input type="checkbox"/> Yes Proceed to question 7</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>7. Will Saxenda be used with another GLP1RA (e.g., Bydureon, Trulicity, Byetta, Adlyxin, Victoza, Soliqua, Xultophy)?</p>	<p><input type="checkbox"/> Yes STOP Coverage not approved</p>	<p><input type="checkbox"/> No Proceed to question 8</p>
<p>8. Does the patient have a history of or family history of medullary thyroid cancer, or multiple endocrine neoplasia syndrome type 2?</p>	<p><input type="checkbox"/> Yes STOP Coverage not approved</p>	<p><input type="checkbox"/> No Proceed to question 9</p>
<p>9. 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)?</p>	<p><input type="checkbox"/> Yes Proceed to question 10</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>10. 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?</p>	<p><input type="checkbox"/> Yes Proceed to question 11</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>11. Is the patient an Active Duty Service Member?</p>	<p><input type="checkbox"/> Yes Proceed to question 12</p>	<p><input type="checkbox"/> No Proceed to question 13</p>
<p>12. Is the individual enrolled in a Service-specific Health/Wellness Program AND adhere to Service policy, AND will remain engaged throughout course of therapy?</p>	<p><input type="checkbox"/> Yes Proceed to question 13</p>	<p><input type="checkbox"/> No STOP Coverage not approved</p>
<p>13. Is the patient pregnant?</p>	<p><input type="checkbox"/> Yes STOP Coverage not approved</p>	<p><input type="checkbox"/> No Sign and date below</p>

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14. Is the patient currently engaged in behavioral modification and on a reduced calorie diet?	<input type="checkbox"/> Yes Proceed to question 15	<input type="checkbox"/> No STOP Coverage not approved
15. Has the patient lost GREATER THAN or EQUAL to 4 percent of baseline body weight since starting medication despite 16 weeks of therapy?	<input type="checkbox"/> Yes Proceed to question 16	<input type="checkbox"/> No STOP Coverage not approved
16. Is the patient pregnant?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 17
17. Is the patient an Active Duty Service Member?	<input type="checkbox"/> Yes Proceed to question 18	<input type="checkbox"/> No Sign and date below
18. 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?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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

[8 January 2020]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: