

**Neighborhood Health Plan of Rhode Island**  
**Prior Authorization Form**  
*Weight Loss Management*

<b>Member Name:</b> (required) _____	<b>Member ID Number:</b> (required) <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>								
<b>Member Date of Birth:</b> (required)    /    /	<b>Member Sex:</b> M    F    (Circle One)								
<b>Prescriber Name:</b> (required) _____	<b>Contact Person at Office:</b> _____								
<b>Office Fax Number:</b> (required) (    ) -	<b>Office Phone number:</b> (required) (    ) -								
<b>Patient Height</b> (required) _____ <b>Patient Weight</b> (required) _____ <b>BMI</b> (required) _____									
<b>Drug Requested</b> (required) <input type="checkbox"/> Phentermine <input type="checkbox"/> OTC Alli <input type="checkbox"/> OTHER(list) _____ <u>For Phentermine:</u> Patient has history of drug abuse <input type="checkbox"/> YES <input type="checkbox"/> NO Patient has moderate/severe uncontrolled hypertension <input type="checkbox"/> YES <input type="checkbox"/> NO patient has advanced arteriosclerosis or CV disease, or hyperthyroidism <input type="checkbox"/> YES <input type="checkbox"/> NO									
Patient is <b>required</b> to be enrolled in weight reduction program. Please provide name or location of weight reduction program _____									
Patient is <b>required</b> to be enrolled in nutritional counseling program. Please provide name or location of nutritional counseling program _____ For information about available nutritional counseling, please call NHPRI Referrals @ 459-6000									
Describe current exercise program for patient _____									
Has patient's PCP been notified that weight reduction medication has been requested? Yes _____ No _____									
Has Patient been counseled on the benefits and risks of therapy? Yes _____ No _____									
Please indicate any VERY HIGH ABSOLUTE Risk Factors / Co-morbid Conditions associated with patient: <input type="checkbox"/> CHD or Atherosclerotic disease <input type="checkbox"/> Type-2 Diabetes <input type="checkbox"/> Sleep apnea	Please indicate any HIGH ABSOLUTE Risk Factors / Co-morbid Conditions associated with patient: <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px; vertical-align: top;"> <input type="checkbox"/> Cigarette smoking  <input type="checkbox"/> Hypertension (&gt;140/90)  <input type="checkbox"/> High risk LDL (&gt;160 mg/dL)           </td> <td style="width: 50%; padding: 5px; vertical-align: top;"> <input type="checkbox"/> Low HDL (&lt;40mg/dL)  <input type="checkbox"/> Fasting plasma Glucose between 100 and 125 mg/dL  <input type="checkbox"/> Family history of premature CHD           </td> </tr> </table>	<input type="checkbox"/> Cigarette smoking <input type="checkbox"/> Hypertension (>140/90) <input type="checkbox"/> High risk LDL (>160 mg/dL)	<input type="checkbox"/> Low HDL (<40mg/dL) <input type="checkbox"/> Fasting plasma Glucose between 100 and 125 mg/dL <input type="checkbox"/> Family history of premature CHD						
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<b>Approval Criteria for initial treatment:</b> <ul style="list-style-type: none"> <li>• BMI <math>\geq 27\text{kg/m}^2</math> and presence of 1 or more very high absolute risks OR</li> <li>• BMI <math>\geq 27\text{kg/m}^2</math> and presence of 3 or more high absolute risks OR</li> <li>• BMI <math>\geq 30\text{kg/m}^2</math></li> </ul> Initial approval for weight reduction medications will be approved for up to 4 weeks. Renewal is based on patient response. <b><i>Please note that patient must lose 4 or more pounds within first 4 weeks to be eligible for renewal.</i></b>									

All information provided on this form is accurate as of this date.

Prescriber's Signature \_\_\_\_\_ NPI \_\_\_\_\_ Date \_\_\_\_\_

Completed form must be faxed to **NHPRI PHARMACY at fax # 866-423-0945**