Neighborhood Health Plan of Rhode Island

Prior Authorization Form

Weight Loss Management

Member Name: (required)	**Member ID Number:** (required)
Member Date of Birth: (required) / /	**Member Sex:** M F (Circle One)
Prescriber Name: (required)	**Contact Person at Office:**
Office Fax Number: (required) ( ) -	**Office Phone number:** (required) ( ) -

Patient Height (required) ________ **Patient Weight** (required) ________ **BMI** (required) ________

Drug Requested (required) ☐ Phentermine ☐ OTC Alli ☐OTHER*(list)* ____________

For Phentermine:

Patient has history of drug abuse ☐ YES ☐ NO

Patient has moderate/severe uncontrolled hypertension ☐ YES ☐ NO

Patient has advanced arteriosclerosis or CV disease, or hyperthyroidism ☐ YES ☐ NO

Patient is **required** to be enrolled in weight reduction program. Please provide name or location of weight reduction program ____

Patient is **required** to be enrolled in nutritional counseling program. Please provide name or location of nutritional counseling program ____________________________________.
For information about available nutritional counseling, please all Neighborhood 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:	Please indicate any HIGH ABSOLUTE Risk Factors / Co-morbid Conditions associated with patient:	
❑ CHD or Atherosclerotic disease ❑ Type-2 Diabetes ❑ Sleep apnea	❑ Cigarette smoking ❑ Hypertension (>140/90) ❑ High risk LDL (>160 mg/dL)	❑ Low HDL (<40mg/dL) ❑ Fasting plasma Glucose between 100 and 125 mg/dL ❑ Family history of premature CHD

Approval Criteria for initial treatment:

- **BMI $\geq$ 27kg/m^2 and presence of 1 or more very high absolute risks OR**
- **BMI $\geq$ 27kg/m^2 and presence of 3 or more high absolute risks OR**
- **BMI $\geq$ 30kg/m^2**

Initial approval for weight reduction medications will be approved for up to 4 weeks. Renewal is based on patient response.

Please note that patient must lose 4 or more pounds within first 4 weeks to be eligible for renewal.

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

Prescriber's Signature______________________ NPI___ __________ Date__________

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