

Neighborhood Health Plan of Rhode Island

Phentermine, OTC Alli

Weight Loss Management RENEWAL form

Drug Requested (required) _____ Quantity _____ Directions _____	
Member Date of Birth: (required) / /	Member Sex: M F (Circle One)
Prescriber Name: (required)	Contact Person at Office:
Office Phone number: (required) () -	Office Fax Number: (required) () -

Patient's weight at time therapy initiated _____ Date _____		
Patient's current weight _____		
Patient's current BMI _____		
Literature suggests that patients who have not demonstrated at least a 4.4 lb (2 kg) weight loss in the first 4 weeks of therapy are unlikely to demonstrate a long-term response		
	Yes	No
1) Side Effects to Medication: If yes, please describe	<input type="checkbox"/>	<input type="checkbox"/>
2) Is Member still active in weight reduction program? • If yes, please provide name or location of program: _____	<input type="checkbox"/>	<input type="checkbox"/>
3) Is Member receiving MANDATORY nutritional counseling? • If yes, date of last appointment: _____	<input type="checkbox"/>	<input type="checkbox"/>
4) Is Member still exercising (if clinically appropriate): • If yes, please describe type : _____	<input type="checkbox"/>	<input type="checkbox"/>

Renewal of weight loss medications is based on weight lost, lack of side effects and adherence to weight reduction program. An approved authorization for appetite suppressants and lipase inhibitors is given for **up to 6 months at a time, with further renewal based on further response.** (Note: phentermine and diethylpropion will only be allowed for six months as they are approved for short-term use only.)

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

Prescriber's Signature _____ Date _____

For updated NHPRI pharmacy information, please supply email address _____

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