

**Neighborhood Health Plan of Rhode Island
Phentermine, OTC Alli**

Weight Loss Management RENEWAL form

Drug Requested (required) _____ Quantity _____ Directions _____
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Member Name: (required) _____	Member ID Number: (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> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>										
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			
	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%;"></td> <td style="width:10%; text-align: center;">Yes</td> <td style="width:10%; text-align: center;">No</td> </tr> </table>		Yes	No
	Yes	No		
1) Side Effects to Medication: If yes, please describe	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%; text-align: center;"><input type="checkbox"/></td> <td style="width:10%; text-align: center;"><input type="checkbox"/></td> <td style="width:10%;"></td> </tr> </table>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>			
2) Is Member still active in weight reduction program? • If yes, please provide name or location of program: _____	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%; text-align: center;"><input type="checkbox"/></td> <td style="width:10%; text-align: center;"><input type="checkbox"/></td> <td style="width:10%;"></td> </tr> </table>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>			
3) Is Member receiving MANDATORY nutritional counseling? • If yes, date of last appointment: _____	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%; text-align: center;"><input type="checkbox"/></td> <td style="width:10%; text-align: center;"><input type="checkbox"/></td> <td style="width:10%;"></td> </tr> </table>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>			
4) Is Member still exercising (if clinically appropriate): • If yes, please describe type : _____	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%; text-align: center;"><input type="checkbox"/></td> <td style="width:10%; text-align: center;"><input type="checkbox"/></td> <td style="width:10%;"></td> </tr> </table>	<input type="checkbox"/>	<input type="checkbox"/>	
<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 Neighborhood pharmacy information, please supply email address _____

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