OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

This is a group specific benefit

Drug Requested: (*check applicable box below*) ***Weight Management Drugs***

❑ **Adipex-P®** (phentermine HCl)	❑ **Belviq®/BelviqXR®** (lorcaserin)
❑ **Contrave®** (naltrexone HCl/bupropion HCl)	❑ **Qsymia®** (phentermine/topiramate ER)
❑ **Xenical®** (orlistat)	❑ **Lomaira™** (phentermine hydrochloride USP)
❑ **Bontril** (phendimetrazine)	❑ **Regimex** (benzphetamine)
❑ **diethylpropion**	

DRUG INFORMATION: Complete information below. Authorization process will be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable***: _____

- ***All of the above medications are Pregnancy Category X.***

CLINICAL CRITERIA*: *At least one of the following criteria MUST be met to qualify. Current height/weight MUST be included. Chart notes/lab results MUST be attached to this request or authorization process will be delayed.

Initial Authorization

Belviq®/Belviq XR® - 12 Weeks Only

ALL other medications listed above - 16 Weeks

Height: _____ Current Weight: _____ BMI:_____

❑ Patient has a BMI of 40 or greater

OR

❑ Patient has a BMI of 35 or greater with co-morbid conditions that may include coronary artery disease, hypertension, CHF, diabetes, dyslipidemia, or sleep apnea.

Comorbid Condition(s):_____ ***(chart notes MUST be attached)***

Continued Approval – 6 months

(contingent upon patient continuing to lose weight up to desired BMI)

- Patients on ***Belviq /Belviq XR®*** therapy should be discontinued if 5% weight loss is not achieved by week 12.
- Patients on ***Contrave®*** therapy should be discontinued if 5% weight loss is not achieved after 12 weeks of maintenance dosing.
- For patients on ***Qsymia®*** therapy should be discontinued or dose escalated if 3% weight loss is not achieved after 12 weeks on 7.5mg/46mg dose. Discontinue ***Qsymia®*** if 5% weight loss in not achieved after 12 weeks on maximum daily dose of 15mg/92mg.

(signature on next page)

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by the Pharmacy and Therapeutics Committee:** 9/17/2009
REVISED/UPDATED: ~~10/6/2014; 10/8/2014; 11/6/2014; 11/20/2014; 1/26/2015; 5/22/2015; 12/29/2015; 11/17/2016; 12/31/2016; 2/8/2017; 3/28/2017; 8/20/2017;~~ **3/7/2018**