Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Contrave® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand** ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

What is the patient's diagnosis for the medication being requested? ____

ICD-10 Code(s): ________________________________

Clinical information:

Does the patient have a body mass index (BMI) of 40 or greater? ❑ **Yes** ❑ **No**

Chart notes/lab documentation must be provided

Does the patient have a BMI of 35 with co-morbid conditions that includes coronary artery disease, hypertension, congestive heart failure, diabetes, dyslipidemia, or sleep apnea? ❑ **Yes** ❑ **No**

If **Yes** to the above, document the co-morbid condition(s):____

Chart notes/lab documentation must be provided

Current height and weight:

Member's current Height: ______________ Weight: ______________

Reauthorization:

If this is a reauthorization request, answer the following:

Has the patient achieved 5% weight loss after 12 weeks of maintenance dosing? ❑ **Yes** ❑ **No**

Chart notes/lab documentation must be provided

Member's current Height: ______________ Weight: ______________

****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.

Prescriber Signature: ______________________ **Date:** _____________________________

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

____

____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

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