

## Qsymia® Prior Authorization Request Form

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NP#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information <small>(required)</small>					
<b>What is the patient's diagnosis for the medication being requested?</b> _____					
ICD-10 Code(s): _____					
<b>Clinical information:</b>					
Does the patient have a body mass index (BMI) of 40 or greater? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Chart notes/lab documentation must be provided</i>					
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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If <b>Yes</b> to the above, document the co-morbid condition(s): _____ <i>Chart notes/lab documentation must be provided</i>					
<b>Current height and weight:</b>					
Member's current Height: _____ Weight: _____					
<b>Reauthorization:</b>					
<b>If this is a reauthorization request, answer the following:</b>					
Has the patient achieved 3% weight loss after 12 weeks on 7.5 mg/46mg dosing? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Chart notes/lab documentation must be provided</i>					
Has the patient achieved 5% weight loss after 12 weeks on 15mg/92mg dosing? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Chart notes/lab documentation must be provided</i>					
Member's current Height: _____ Weight: _____					
<b>**Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.**</b>					
<b>*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*</b>					
<b>Prescriber Signature:</b> _____ <b>Date:</b> _____					

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.

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