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

Qsymia® 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**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

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 3% weight loss after 12 weeks on 7.5 mg/46mg dosing? ❑ **Yes** ❑ **No**
Chart notes/lab documentation must be provided

Has the patient achieved 5% weight loss after 12 weeks on 15mg/92mg 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.