Excellus

Drug Prior Authorization FAX Form

Weight Related Comorbidities
For
Overweight, Obesity, Cardiovascular Disease
(New Start and Recertification)

Complete form and fax to:
Pharmacy Help Desk
Fax #: 1-800-956-2397
Phone #: 1-800-724-5033

Complete all the following Patient/Physician Information: (Please Print)

Patient Information	
Patient Name:	Patient Phone #: ( )
Patient ID #	Patient Birthdate:
List Patient Allergy (If Any)	
Prescriber Information	
Prescriber Name:	Prescriber Specialty:
Prescriber Address:	
Prescriber Phone #:	Prescriber Fax #:
Prescriber NPI #:	Office Contact: Extension:

***PARTICIPATION IN AN APPROVED WEIGHT MANAGEMENT PROGRAM IS REQUIRED**

1. Has the patient been enrolled in a comprehensive weight management program, consisting of diet modification, nutritional counseling, behavioral modifications, and exercise components for the last 3 months?	☐ **Yes** ☐ **No**
2. Provide the name of the weight management program: _____ ***Examples:** Qualifying office-based counseling, Weight Watchers, Noom (not an all-inclusive list)	☐ **Yes** ☐ **No**
3. Has the patient regularly attended program and had monthly individual/group coaching on weight management? *****(Proof of current and prior enrollment required for all initial requests)*****	☐ **Yes** ☐ **No**

Medication/Medical and Dispensing Information (Select which medication is being requested)

☐ **Contrave**	☐ **Orlistat**	☐ **Qsymia**	☐ **Saxenda**	☐ **Wegovy**	☐ **Xenical**	☐ **Zepbound**

Dose	**Frequency**	**Height**	**Weight (lbs. or kg) & Date**	**Procedure Code**
			/	

Diagnosis/ICD-10:

Is this request for a: ☐ New Start **OR** ☐ Continuation of Therapy (recertification)? Start Date: _____

Will the prescribed drug be used in combination with other weight loss drugs? **If yes, please list:** _____	☐ **Yes** ☐ **No**
If requesting brand Xenical, is there a medical reason why the patient cannot use generic orlistat? **If yes, please explain:** _____	☐ **Yes** ☐ **No**

Supply the following information (fill in all which apply)

	Date	**Weight (lbs. or kg)**	**BMI**
3-month Prior Start			
Baseline:			
3 months:			
6 months:			
9 months:			
1 year:			
18 months:			

Questions/Indications for Medical Necessity

**** See the Weight Related Comorbidities Policy (Pharmacy-03) for full Prior Authorization criteria ****

Co-Morbidities (Select all which apply):

☐ Cardiovascular Disease (MI, angina, surgery/procedures)
☐ Dyslipidemia (ex. high LDL, TG, or low HDL)
☐ Hypercholesterolemia
☐ Hypertension
☐ Metabolic Syndrome
☐ Dyslipidemia (ex. high LDL, TG, or low HDL)
☐ Metabolic Dysfunction-Associated Steatotic Liver Disease (MAFLD)
☐ Pulmonary Hypoventilation
☐ Obstructive Sleep Apnea
☐ Weight Bearing Joint Arthropathy

Prescriber Signature: _____ **Date:** _____
I certify the above information is true and accurate to the best of my knowledge.