PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 7/5/2026
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
_____ **NPI#:** **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**
_

Drug Name (specify drug) _____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1. Will the requested drug be used with a reduced-calorie diet AND increased physical activity to reduce excess body weight or maintain weight reduction long term in an adult? **Y** ☐ **N** ☐
2. Has the patient completed at least 3 months of therapy with the requested drug at a stable maintenance dose? [If the patient is transitioning from another drug therapy for weight loss, please answer no and proceed.] **Y** ☐ **N** ☐
3. Has the patient lost at least 5 percent of baseline body weight OR has the patient continued to maintain their initial 5 percent weight loss? ACTION REQUIRED: If yes, then documentation is required for approval. Document the patient's weight prior to starting drug therapy for weight loss and the patient's current weight, including the dates the weights were taken. **Y** ☐ **N** ☐
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4. Has documentation of the patient's weight prior to starting drug therapy for weight loss and the patient's current weight, including the dates the weights were taken been submitted to CVS Health? **Y** ☐ **N** ☐
5. Does the patient require MORE than the plan allowance of 30 tablets per month of Foundayo (orforglipron)? **Y** ☐ **N** ☐
6. Has the patient participated in a comprehensive weight management program that encourages behavioral modification, reduced-calorie diet, AND increased physical activity with continuing follow-up for at least 6 months prior to using drug therapy? **Y** ☐ **N** ☐
7. Does the patient have a baseline body mass index (BMI) of less than 27 kg/m2? [If the patient is transitioning from another drug therapy for weight loss, please consider their baseline BMI at the start of any drug therapy when answering this question.] **Y** ☐ **N** ☐
8. Does the patient have a baseline body mass index (BMI) of 27 kg/m2 to less than 30 kg/m2? [If the patient is transitioning from another drug therapy for weight loss, please consider their baseline BMI at the start of any drug therapy when answering this question.] ACTION REQUIRED: If yes, then prescriber MUST submit chart notes that show the patient's baseline BMI. **Y** ☐ **N** ☐
   _____
9. Have chart notes showing the patient's baseline body mass index (BMI) been submitted to CVS Health? [If the patient is transitioning from another drug therapy for weight loss, please provide their baseline BMI at the start of any drug therapy.] ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐
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10. Does the patient have at least ONE weight-related comorbid condition (e.g., hypertension, type 2 diabetes mellitus, dyslipidemia)? [If the patient is transitioning from another drug therapy for weight loss, please consider their weight-related comorbid condition(s) at the start of any drug therapy when answering this question.] ACTION REQUIRED: If yes, then prescriber MUST submit chart notes that indicate the patient's weight-related comorbid condition(s). **Y** ☐ **N** ☐

11. Have chart notes indicating the patient's weight-related comorbid condition(s) been submitted to CVS Health? [If the patient is transitioning from another drug therapy for weight loss, please provide their weight-related comorbid condition(s) at the start of any drug therapy.] ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

12. Does the patient have a baseline body mass index (BMI) of 30 kg/m2 to less than 35 kg/m2? [If the patient is transitioning from another drug therapy for weight loss, please consider their baseline BMI at the start of any drug therapy when answering this question.] ACTION REQUIRED: If yes, then prescriber MUST submit chart notes that show the patient's baseline BMI. **Y** ☐ **N** ☐

13. Have chart notes showing the patient's baseline body mass index (BMI) been submitted to CVS Health? [If the patient is transitioning from another drug therapy for weight loss, please provide their baseline BMI at the start of any drug therapy.] **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

14. Does the patient have a baseline body mass index (BMI) of 35 kg/m2 to less than 40 kg/m2? [If the patient is transitioning from another drug therapy for weight loss, please consider their baseline BMI at the start of any drug therapy when answering this question.] ACTION REQUIRED: If yes, then prescriber MUST submit chart notes that show the patient's baseline BMI. **Y** ☐ **N** ☐

15. Have chart notes showing the patient's baseline body mass index (BMI) been submitted to CVS Health? [If the patient is transitioning from another drug therapy for weight loss, please provide their baseline BMI at the start of any drug therapy.] **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

16. Does the patient have a baseline body mass index (BMI) of 40 kg/m2 or greater? [If the patient is transitioning from another drug therapy for weight loss, please consider their baseline BMI at the start of any drug therapy when answering this question.] ACTION REQUIRED: If yes, then prescriber MUST submit chart notes that show the patient's baseline BMI. **Y** ☐ **N** ☐

17. Have chart notes showing the patient's baseline body mass index (BMI) been submitted to CVS Health? [If the patient is transitioning from another drug therapy for weight loss, please provide their baseline BMI at the start of any drug therapy.] **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

18. Does the patient require MORE than the plan allowance of 30 tablets per month of Foundayo (orforglipron)? **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date