CAREFIRST F3
Saxenda

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Saxenda.

Patient Information

Patient Name:

Patient Phone: ☐☐☐-☐☐☐-☐☐☐☐

Patient ID:

Patient Group:

Patient DOB: ☐☐/☐☐/☐☐☐☐

Physician Information

Physician Name

Physician Phone: ☐☐☐-☐☐☐-☐☐☐☐

Physician Fax: ☐☐☐-☐☐☐-☐☐☐☐

Physician Addr.:

City, St, Zip:

Drug Name (select from list of drugs shown)

Saxenda (liraglutide)

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 for chronic weight management?	**Y** ☐	**N** ☐
2.	Is the patient 18 years of age or older?	**Y** ☐	**N** ☐
3.	Has the patient completed at least 16 weeks of therapy with the requested drug?	**Y** ☐	**N** ☐
4.	Has the patient lost at least 4 percent of baseline body weight OR has the patient continued to maintain their initial 4 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** ☐
5.	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** ☐
6.	Does the patient require MORE than the plan allowance of 1 package of five 18mg/3mL pens per month?	**Y** ☐	**N** ☐
7.	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** ☐
8.	Does the patient have a baseline body mass index (BMI) of less than 27 kg/m2?	**Y** ☐	**N** ☐
9.	Does the patient have a baseline body mass index (BMI) of 27 kg/m2 to less than 30 kg/m2? _____	**Y** ☐	**N** ☐

10. Have chart notes showing the patient's baseline body mass index (BMI) been submitted to CVS Health? **Y** ☐ **N** ☐

11. Does the patient have at least one weight-related comorbid condition (e.g., hypertension, type 2 diabetes mellitus, dyslipidemia)? **Y** ☐ **N** ☐

12. Have chart notes indicating the patient's weight-related comorbid condition(s) been submitted to CVS Health? **Y** ☐ **N** ☐

13. Does the patient have a baseline body mass index (BMI) of 30 kg/m2 to less than 35 kg/m2? **Y** ☐ **N** ☐

14. Have chart notes showing the patient's baseline body mass index (BMI) been submitted to CVS Health? **Y** ☐ **N** ☐

15. Does the patient have a baseline body mass index (BMI) of 35 kg/m2 to less than 40 kg/m2? **Y** ☐ **N** ☐

16. Have chart notes showing the patient's baseline body mass index (BMI) been submitted to CVS Health? **Y** ☐ **N** ☐

17. Does the patient have a baseline body mass index (BMI) of 40 kg/m2 or greater? **Y** ☐ **N** ☐

18. Have chart notes showing the patient's baseline body mass index (BMI) been submitted to CVS Health? **Y** ☐ **N** ☐

19. Does the patient require MORE than the plan allowance of 1 package of five 18mg/3mL pens per month? **Y** ☐ **N** ☐

20. Is the patient 12 to 17 years of age? **Y** ☐ **N** ☐

21. Has the patient completed at least 12 weeks on the maintenance dose of therapy with the requested drug? **Y** ☐ **N** ☐

22. Has the patient had at least 1 percent reduction in body mass index (BMI) from baseline OR has the patient continued to maintain their initial 1 percent reduction in BMI from baseline? ACTION REQUIRED: If yes, then documentation is required for approval. Document the patient's BMI prior to starting drug therapy for weight loss and the patient's current BMI, including the dates the BMIs were taken: **Y** ☐ **N** ☐

23. Has documentation of the patient's body mass index (BMI) prior to starting drug therapy for weight loss and the patient's current BMI, including the dates the BMIs were taken been submitted to CVS Health? **Y** ☐ **N** ☐

24. Does the patient require MORE than the plan allowance of 1 package of five 18mg/3mL pens per month? **Y** ☐ **N** ☐

25. 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** ☐

26. Does the patient have a baseline body weight above 60 kg? **Y** ☐ **N** ☐

27. Have chart notes showing the patient's baseline body weight been submitted to CVS Health? **Y** ☐ **N** ☐

28. Does the patient have a baseline body mass index (BMI) corresponding to 30 kg/m2 or greater for adults by international cut-offs based on the Cole Criteria? **Y** ☐ **N** ☐

29. Have chart notes showing the patient's baseline corresponding body mass index (BMI) for adults by international cut-offs based on the Cole Criteria been submitted to CVS Health? **Y** ☐ **N** ☐

30. Does the patient require MORE than the plan allowance of 1 package of five 18mg/3mL pens per month? **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