Prior Authorization Form

CAREFIRST

Xenical

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Xenical .

Drug Name (select from list of drugs shown)

Orlistat Capsules Xenical (orlistat)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Will the requested drug be used with a reduced calorie diet and increased physical activity for obesity management? Y N

[If Yes, then go to 2. If No, then no further questions.]

2. Has the patient completed at least 6 months of therapy with the requested drug? Y N

[If Yes, then go to 3. If No, then go to 5.]

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, Y N _____

	then documentation is required for approval. Document the patient's weight prior to starting Xenical therapy and the patient's current weight after Xenical therapy, including the date the weights were taken:		
	[If Yes, then go to 4. If No, then no further questions.]		
4.	Has documentation of the patient's weight prior to starting Xenical therapy and the patient's current weight after Xenical therapy, including the date the weights were taken been submitted to CVS Health?	Y N	
	[If Yes, then go to 17. If No, then no further questions.]		
5.	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	
	[If Yes, then go to 6. If No, then no further questions.]		
6.	Does the patient have a body mass index (BMI) of less than 27 kg/m2?	Y N	
	[If Yes, then no further questions. If No, then go to 7.]		
7.	Does the patient have a body mass index (BMI) of 27 kg/m2 to less than 30 kg/m2? ACTION REQUIRED: If yes, then prescriber MUST submit chart notes that show the patient's current BMI.	Y N	
	[If Yes, then go to 8. If No, then go to 11.]		
8.	Have chart notes showing the patient's current body mass index (BMI) been submitted to CVS Health? ACTION REQUIRED: Submit supporting documentation	Y N	
	[If Yes, then go to 9. If No, then no further questions.]		
9.	Does the patient have at least one weight-related comorbid condition (e.g., hypertension, type 2 diabetes mellitus, dyslipidemia)? ACTION REQUIRED: If yes, then prescriber MUST submit chart notes that indicate the patient's weight-related comorbid condition(s).	Y N	
	[If Yes, then go to 10. If No, then no further questions.]		
10.	Have chart notes indicating the patient's current weight-related comorbid condition(s) been submitted to CVS Health? ACTION REQUIRED: Submit supporting documentation	Y N	
	[If Yes, then go to 17. If No, then no further questions.]		
11.	Does the patient have a body mass index (BMI) of 30 kg/m2 to less than 35 kg/m2? ACTION REQUIRED: If yes, then prescriber MUST submit chart notes that show the patient's current BMI.	Y N	
	[If Yes, then go to 12. If No, then go to 13.]		

12. Have chart notes showing the patient's current body mass index (BMI) been submitted to CVS Health? ACTION REQUIRED: Submit supporting documentation	Y N	
[If Yes, then go to 17. If No, then no further questions.]		
13. Does the patient have a body mass index (BMI) of 35 kg/m2 to less than 40 kg/m2? ACTION REQUIRED: If yes, then prescriber MUST submit chart notes that show the patient's current BMI.	Y N	
[If Yes, then go to 14. If No, then go to 15.]		
14. Have chart notes showing the patient's current body mass index (BMI) been submitted to CVS Health? ACTION REQUIRED: Submit supporting documentation	Y N	
[If Yes, then go to 17. If No, then no further questions.]		
15. Does the patient have a body mass index (BMI) of 40 kg/m2 or greater? ACTION REQUIRED: If yes, then prescriber MUST submit chart note that show the patient's current BMI.	Y N	
[If Yes, then go to 16. If No, then no further questions.]		
16. Have chart notes showing the patient's current body mass index (BMI) been submitted to CVS Health? ACTION REQUIRED: Submit supporting documentation	Y N	
[If Yes, then go to 17. If No, then no further questions.]		
17. Does the patient require MORE than the plan allowance of 90 capsules per month?	Y N	
[No further questions.]		

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