

8.	Have chart notes indicating the patient's current weight-related comorbid condition(s) been submitted to CVS Health? ACTION REQUIRED: Submit supporting documentation	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
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9.	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	<input type="checkbox"/>	N	<input type="checkbox"/>
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10.	Have chart notes showing the patient's current body mass index (BMI) been submitted to CVS Health? ACTION REQUIRED: Submit supporting documentation	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
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11.	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	<input type="checkbox"/>	N	<input type="checkbox"/>
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12.	Have chart notes showing the patient's current body mass index (BMI) been submitted to CVS Health? ACTION REQUIRED: Submit supporting documentation	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
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13.	Does the patient have a body mass index (BMI) of 40 kg/m2 or greater? ACTION REQUIRED: If yes, then prescriber MUST submit chart notes that show the patient's current BMI.	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
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14.	Have chart notes showing the patient's current body mass index (BMI) been submitted to CVS Health? ACTION REQUIRED: Submit supporting documentation	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
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15.	Is this request for phentermine?	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
16.	Will phentermine be used in a patient who is also using Fintepla (fenfluramine)?	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
17.	Does the patient require MORE than the plan allowance of any of the following per month: A) 30 units of Adipex-P (phentermine) 37.5 mg, B) 90 tablets of Lomaira 8 mg, C) 60 capsules of phentermine 15 mg, D) 30 capsules of phentermine 30 mg?	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
18.	Is this request for benzphetamine?	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
19.	Does the patient require MORE than the plan allowance of 90 tablets per month?	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
20.	Is this request for diethylpropion?	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
21.	Does the patient require MORE than the plan allowance of any of the following per month: A) 90 tablets of diethylpropion immediate-release 25 mg, B) 30 tablets of diethylpropion extended-release 75 mg?	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
22.	Does the patient require MORE than the plan allowance of any of the following per month: A) 180 tablets of phendimetrazine immediate-release 35 mg, B) 30 capsules of phendimetrazine extended-release 105 mg?	Y	<input type="checkbox"/>	N	<input type="checkbox"/>

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

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