CAREFIRST DC
Phentermine/Phendimetrazine/Didrex/Diethylpropion

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 855-582-2038 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Phentermine/Phendimetrazine/Didrex/Diethylpropion.

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 (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.	Has the patient received 3 months of therapy with the requested drug within the past 365 days?	**Y** ☐	**N** ☐
2.	Will the requested drug be used with a reduced calorie diet and increased physical activity in the management of exogenous obesity?	**Y** ☐	**N** ☐
3.	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** ☐
4.	Does the patient have a body mass index (BMI) of less than 27 kg/m2?	**Y** ☐	**N** ☐
5.	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** ☐
6.	Have chart notes showing the patient's current body mass index (BMI) been submitted to CVS Health? ACTION REQUIRED: Submit supporting documentation _____	**Y** ☐	**N** ☐
7.	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** ☐

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** ☐	**N** ☐
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** ☐	**N** ☐
10.	Have chart notes showing the patient's current body mass index (BMI) been submitted to CVS Health? ACTION REQUIRED: Submit supporting documentation	**Y** ☐	**N** ☐
11.	Does the patient have a body mass index (BMI) of 35 kg/2 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** ☐
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** ☐
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** ☐	**N** ☐
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** ☐
15.	Is this request for phentermine?	**Y** ☐	**N** ☐
16.	Will phentermine be used in a patient who is also using Fintepla (fenfluramine)?	**Y** ☐	**N** ☐
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** ☐	**N** ☐
18.	Is this request for benzphetamine?	**Y** ☐	**N** ☐
19.	Does the patient require MORE than the plan allowance of 90 tablets per month?	**Y** ☐	**N** ☐
20.	Is this request for diethylpropion?	**Y** ☐	**N** ☐
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** ☐	**N** ☐
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** ☐	**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