PA Request Criteria

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247135

CAREFIRST
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 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Phentermine/Phendimetrazine/Didrex/Diethylpropion.

Patient Name: _____ **Date:** 12/26/2025
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. 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 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** ☐
5. 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** ☐
6. 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** ☐
7. 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** ☐
8. 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** ☐

9. 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** ☐

10. 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** ☐

11. 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** ☐

12. 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** ☐

13. 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** ☐

14. 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** ☐

15. Is this request for phentermine hydrochloride? **Y** ☐ **N** ☐

16. Does the patient require MORE than the plan allowance of any of the following: A) 30 units per month of Adipex-P (phentermine hydrochloride) 37.5 mg, B) 90 tablets per month of Lomaira (phentermine hydrochloride) 8 mg, C) 60 capsules per month of phentermine hydrochloride 15 mg, D) 30 capsules per month of phentermine hydrochloride 30 mg? **Y** ☐ **N** ☐

17. Is this request for benzphetamine hydrochloride? **Y** ☐ **N** ☐

18. Does the patient require MORE than the plan allowance of 90 tablets per month of benzphetamine hydrochloride 50 mg? **Y** ☐ **N** ☐

19. Is this request for diethylpropion hydrochloride? **Y** ☐ **N** ☐

20. Does the patient require MORE than the plan allowance of any of the following: A) 90 tablets per month of diethylpropion hydrochloride immediate-release 25 mg, B) 30 tablets per month of diethylpropion hydrochloride extended-release 75 mg? **Y** ☐ **N** ☐

21. Does the patient require MORE than the plan allowance of any of the following: A) 180 tablets per month of phendimetrazine tartrate immediate-release 35 mg, B) 30 capsules per month of Phendimetrazine tartrate 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.

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Prescriber (Or Authorized) Signature and Date