BlueCross BlueShield Federal Employee Program

WEIGHT LOSS MEDICATIONS PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

NOTE: Form must be completed in its **entirety** for processing

Please select medication below:

❑**Adipex-P**	❑**Diethylpropion 75mg**	❑**Phentermine**
❑**Benzphetamine**	❑**Lomaira (phentermine) 8mg**	❑**Plenity (carboxymethylcellulose/cellulose/citric acid)**
❑**Contrave (naltrexone/bupropion)**	❑**Phendimetrazine ER capsules**	❑**Qsymia (phentermine/topiramate ER)**
❑**Diethylpropion 25mg**	❑**Phendimetrazine tablets**	❑**Xenical (orlistat)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

****Non-covered branded medications must go through prior authorization and the formulary exception process**

Is this request for brand or generic? ❑Brand ❑Generic

1. How many capsules/tablets/units will the patient need every 90 days? _____ cap(s)/tab(s)/unit(s) per 90 days
2. What is the patient's diagnosis?
   - ❑Chronic weight management
   - ❑Obesity, used for chronic weight management
   - ❑Elevated BMI, used for chronic weight management
   - ❑None of the above
3. Has the patient participated in a comprehensive weight management program such as Teladoc or another weight loss program? ❑Yes ❑No
4. Will this medication be used in combination with another *Prior Authorization (PA) medication for weight loss? ❑Yes* ❑No
   If YES, please specify the medication: _____
   PA Medications: Adipex-P, benzphetamine, Contrave (naltrexone/bupropion), diethylpropion, Imcivree (setmelanotide), Lomaira (phentermine), phendimetrazine, phentermine, Plenity (carboxymethylcellulose-cellulose-citric acid), Qsymia (phentermine/topiramate ER), Saxenda (liraglutide), Wegovy (semaglutide), Xenical (orlistat), Zepbound (tirzepatide)
5. Has the patient been on this medication continuously for the last **4 months** excluding samples? ***Please select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

   a. **Age 12-17**: What is the patient's body mass index (BMI) percentile for their age? ***Please select answer below:***
   ❑Less than 95th percentile **OR** ❑Greater than or equal to 95th percentile

   b. **Age 18 or older**: Please answer the following question:

   i. What is the patient's body mass index (BMI) in kilograms per square meter (kg/m^2)? ***Please select answer below:***
   ❑Less than 27 kg/m^2 ❑Between 27 kg/m^2 and 29.9 kg/m^2 ❑Greater than or equal to 30kg/m^2

   ii. **If BMI is between 27 kg/m^2 and 29.9 kg/m^2**: Does the patient have **ONE** of the listed weight related comorbid conditions **OR** established cardiovascular disease? ***Please select answer below:***

❑ Type 2 diabetes mellitus	❑ Cerebrovascular disease	❑ Myocardial infarction (MI)
❑ Dyslipidemia	❑ Peripheral artery disease (PAD)	❑ Unstable angina
❑ Hypertension	❑ Coronary heart disease	❑ Coronary or other arterial revascularization
❑ Congenital heart disease	❑ Acute coronary syndrome (ACS)	❑ Prior percutaneous coronary intervention/coronary bypass surgery
❑**None of the above**		

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

   a. **Age 12-17**: Has the patient maintained clinically significant weight loss? ❑Yes ❑No

   b. **Age 18 or older**: Has the patient lost at least 5 percent of their baseline body weight? ❑Yes ❑No*
   If NO, has the patient continued to maintain their initial 5 percent weight loss? ❑Yes ❑No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Weight Loss Meds – FEP MD Fax Form Revised 1/1/2025