US Family Health Plan
Prior Authorization Request Form for
benzphetamine, diethylpropion, phendimetrazine IR and SR, phentermine (Anti Obesity Agents)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **855-273-5735**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Initial therapy approves for 3 months, renewal approves for 12 months.
For renewal of therapy an initial USFHP/ Tricare prior authorization approval is required. **usfamilyhealth.org/rx-pa**

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the USFHP/ TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication*	☐ Yes (subject to verification) Proceed to question **11**	☐ No Proceed to question **2**
2. Is the patient GREATER THAN or EQUAL to 18 years of age?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have a history of cardiovascular disease (e.g., arrhythmias, coronary artery disease, heart failure, stroke, uncontrolled hypertension), hyperthyroidism, or other significant contraindication to benzphetamine, diethylpropion, phendimetrazine IR and SR or phentermine?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **4**
4. Does the patient have BMI GREATER THAN or EQUAL to 30, or a BMI GREATER THAN or EQUAL to 27 for those with risk factors in addition to obesity (diabetes, impaired glucose tolerance, dyslipidemia, hypertension, sleep apnea)?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the patient engaged in a trial of behavioral modification and dietary restriction for at least 6 months and failed to achieve the desired weight loss, and will remain engaged throughout course of therapy?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the patient an Active Duty Service Member?	☐ Yes Proceed to question **7**	☐ No Proceed to question **8**

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7. Is the individual enrolled in a Service-specific Health/Wellness Program AND adhere to Service policy, AND will remain engaged throughout course of therapy?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **9**
9. Does the patient have impaired glucose tolerance or diabetes?	☐ Yes Proceed to question **10**	☐ No **Sign and date below**
10. Has the patient tried metformin first, or is concurrently taking metformin?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
11. Is the patient currently engaged in behavioral modification and on a reduced calorie diet?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Has the patient lost GREATER THAN or EQUAL to 5 percent of baseline body weight since starting medication?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **14**
14. Is the patient an Active Duty Service Member?	☐ Yes Proceed to question **15**	☐ No **Sign and date below**
15. Does the individual continue to be enrolled in a Service-specific Health/Wellness Program AND adheres to Service policy, AND will remain engaged throughout course of therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date