US Family Health Plan
Prior Authorization Request Form for
naltrexone SR/ bupropion SR (**Contrave**)

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 **617-562-5296**

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 4 months, renewal approves for 12 months

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. Is this request for continuation of therapy?	☐ Yes **Proceed to question 14**	☐ 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. Has the patient tried and failed to achieve a 5 percent reduction in baseline weight after a 12 week course of phentermine, benzphetamine, diethylpropion, or phendimetrazine?	☐ Yes **Proceed to question 5**	☐ No **Proceed to question 4**
4. Does the patient have a history of cardiovascular disease (e.g. arrhythmias, coronary artery disease, heart failure, stroke, uncontrolled hypertension), hyperthyroidism, or significant contraindication to phentermine, benzphetamine, diethylpropion, or phendimetrazine?	☐ Yes **Proceed to question 5**	☐ No **STOP** **Coverage not approved**
5. Is the patient on concurrent opioid therapy, have a seizure disorder, or have uncontrolled hypertension?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 6**
6. Is the patient currently on a monoamine oxidase inhibitor (e.g., Emsam, Marplan, Nardil), or another formulation of bupropion or naltrexone?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 7**

7. 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 8**	☐ No **STOP** **Coverage not approved**
8. Has the patient engaged in a trial of behavioral modification and dietary restriction for at least 6 months and has failed to achieve the desired weight loss, and will remain engaged throughout course of therapy?	☐ Yes **Proceed to question 9**	☐ No **STOP** **Coverage not approved**
9. Is the patient an Active Duty Service Member?	☐ Yes **Proceed to question 10**	☐ No **Proceed to question 11**
10. 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 11**	☐ No **STOP** **Coverage not approved**
11. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 12**
12. Does the patient have impaired glucose tolerance or diabetes?	☐ Yes **Proceed to question 13**	☐ No **Sign and date below**
13. Has the patient tried metformin first, or is concurrently taking metformin?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
14. Is the patient currently engaged in behavioral modification and on a reduced calorie diet?	☐ Yes **Proceed to question 15**	☐ No **STOP** **Coverage not approved**
15. Has the patient lost GREATER THAN or EQUAL to 5 percent of baseline body weight since starting medication?	☐ Yes **Proceed to question 16**	☐ No **STOP** **Coverage not approved**
16. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 17**
17. Is the patient an Active Duty Service Member?	☐ Yes **Proceed to question 18**	☐ No **Sign and date below**
18. 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