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 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 4 months, renewal approves for 12 months. For renewal of therapy an initial Tricare prior authorization approval is required.

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 TRICARE benefit in the last 6 months?** *Please choose "No" if the patient did not previously have a TRICARE approved PA for Contrave*	☐ Yes (subject to verification) Proceed to question **13**	☐ 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 generic phentermine?**	☐ Yes Proceed to question **4**	☐ No Proceed to question **5**
	4. **Has the patient tried and failed to achieve a 5 percent reduction in baseline weight after a 12 week course of phentermine?**	☐ Yes Proceed to question **6**	☐ No **Proceed to question 5**
	5. **Does the patient have a history of cardiovascular disease (for example, arrhythmias, coronary artery disease, heart failure, stroke, uncontrolled Hypertension), hyperthyroidism, or significant contraindication to phentermine?**	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
	6. **Is the patient on concurrent opioid therapy, have a seizure disorder, or have uncontrolled hypertension?**	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **7**

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	Yes	No
7. Is the patient currently on a monoamine oxidase inhibitor (for example, Emsam, Marplan, Nardil), or another formulation of bupropion or naltrexone?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **8**
8. 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 **9**	☐ No **STOP** **Coverage not approved**
9. 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 **10**	☐ No **STOP** **Coverage not approved**
10. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **11**
11. Does the patient have impaired glucose tolerance or diabetes?	☐ Yes Proceed to question **12**	☐ No **Sign and date below**
12. Has the patient tried metformin first, or is concurrently taking metformin?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
13. Is the patient currently engaged in behavioral modification and on a reduced calorie diet?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Has the patient lost GREATER THAN or EQUAL to 5 percent of baseline body weight since starting medication?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3

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

_____   _____
Prescriber Signature   Date