US Family Health Plan
Prior Authorization Request Form for
liraglutide 3 mg injection (**Saxenda**)

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. 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 Saxenda*	☐ Yes (subject to verification) **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 or has a contraindication to ALL of the following agents: generic phentermine, Qsymia, Xenical, Contrave, and Belviq or Belviq XR?	☐ Yes **Proceed to question 4**	☐ No **STOP Coverage not approved**

4. Please provide the date and duration for each medication listed below.

Phentermine: Date_____ **Duration of therapy** _____
Qsymia: Date _____ **Duration of therapy** _____
Xenical: Date _____ **Duration of therapy** _____
Contrave: Date _____ **Duration of therapy** _____
Belviq/Belviq XR: Date _____ **Duration of therapy** _____

Proceed to question 5

5. Is the patient diabetic?	☐ Yes **Proceed to question 6**	☐ No **Proceed to question 7**

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6. Has the patient tried and failed metformin and the preferred GLP1-RAs (Bydureon and Trulicity)?	☐ Yes **Proceed to question 7**	☐ No **STOP** **Coverage not approved**
7. Will Saxenda be used with another GLP1RA (e.g., Bydureon, Trulicity, Byetta, Adlyxin, Victoza, Soliqua, Xultophy)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 8**
8. Does the patient have a history of or family history of medullary thyroid cancer, or multiple endocrine neoplasia syndrome type 2?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 9**
9. 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 10**	☐ No **STOP** **Coverage not approved**
10. 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 11**	☐ No **STOP** **Coverage not approved**
11. Is the patient an Active Duty Service Member?	☐ Yes **Proceed to question 12**	☐ No **Proceed to question 13**
12. 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 13**	☐ No **STOP** **Coverage not approved**
13. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

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 4 percent of baseline body weight since starting medication despite 16 weeks of therapy?	☐ 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