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 12 months; annual renewal 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 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 BMI GREATER THAN or EQUAL to 30, or a BMI GREATER THAN or EQUAL to 27 in the presence of at least one weight-related comorbidity (diabetes, impaired glucose tolerance, dyslipidemia, hypertension, sleep apnea)?	☐ Yes **Proceed to question 4**	☐ No **STOP Coverage not approved**
4. 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 5**	☐ No **STOP Coverage not approved**
5. Has the patient tried and failed to achieve a 5 percent reduction in baseline weight after a 12 week course of phentermine, benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR?	☐ Yes **Proceed to question 8**	☐ No **Proceed to question 6**

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6. Does the patient have a contraindication to generic phentermine, benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR (for example, arrhythmias, coronary artery disease, heart failure, stroke, uncontrolled hypertension, hyperthyroidism, etc.)?	☐ Yes **Proceed to question 8**	☐ No **Proceed to question 7**
7. Has the patient experienced an adverse reaction to phentermine, benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR that is not expected to occur with Contrave?	☐ Yes **Proceed to question 8**	☐ No **STOP** **Coverage not approved**
8. Is the patient on concurrent opioid therapy, or does the patient have a seizure disorder?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 9**
9. 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 10**
10. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
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 **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

[28 August 2024]