TRICARE 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

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Initial therapy approves for 12 months; annual renewal required. Clinical documentation may be 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.	**Under penalties for false claims against the United States government, I declare that I have examined the patient, and the statements made are true, correct, and complete to the best of my professional knowledge**	☐ **Acknowledged** Proceed to Question 2	
2.	**Is the prescriber an MTF or TRICARE Network provider who has billed TRICARE for professional services provided to assess the patient and develop a treatment plan?**	☐ Yes (subject to verification) Proceed to question 3	☐ No **STOP – Coverage not approved**
3.	**What TRICARE plan is the patient enrolled in?** *(for more information see https://tricare.mil/Plans/HealthPlans)*	☐ TRICARE Select **–** Proceed to Question **4** ☑ TRICARE Prime **–** Proceed to Question **4** ☐ Other TRICARE health plan enrollment that is not TRICARE Select or TRICARE Prime – **STOP - Coverage not approved**	
4.	**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 **14**	☐ No Proceed to question **5**
5.	**Is the patient GREATER THAN or EQUAL to 18 years of age?**	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6.	**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 **7**	☐ No **STOP** **Coverage not approved**

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	7. The provider affirms that the patient has been engaged in behavioral modification and dietary restriction for at least 6 months and has failed to achieve the desired weight loss, will remain engaged throughout course of therapy, AND the provider has documented this in the medical record.	☐ Yes (subject to verification) Proceed to question **8**	☐ No **STOP** **Coverage not approved**
	8. 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 **11**	☐ No Proceed to question **9**
	9. 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 **11**	☐ No Proceed to question **10**
	10. 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 **11**	☐ No **STOP** **Coverage not approved**
	11. Is the patient on concurrent opioid therapy, or does the patient have a seizure disorder?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
	12. 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 **13**
	13. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
	14. The provider affirms that the patient is currently engaged in behavioral modification, on a reduced calorie diet, AND the provider continues to maintain documentation in the medical record.	☐ Yes (subject to verification) 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 **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 _____

[31 August 2025]