US Family Health Plan

Prior Authorization Request Form for

Phentermine 8 mg tablets (Lomaira)

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 approval is 3 months, renewal is 12 months. For renewal of therapy an initial 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 Lomaira*	☐ 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 **STOP** **Coverage not approved**
4. Does the patient require a dose of phentermine less than 15 mg due to elevated baseline heart rate?	☐ Yes **Proceed to question 5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a history of cardiovascular disease (e.g., arrhythmias, coronary artery disease, heart failure, stroke, uncontrolled hypertension), hyperthyroidism, or other significant contraindication to the requested medication?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 6**

6. 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 7**	☐ No **STOP** **Coverage not approved**
7. Has the patient has 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 8**	☐ No **STOP** **Coverage not approved**
8. Is the patient an Active Duty Service Member?	☐ Yes **Proceed to question 9**	☐ No **Proceed to question 10**
9. 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 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 **Proceed to question 16**
16. Is the patient an Active Duty Service Member?	☐ Yes **Proceed to question 17**	☐ No **Sign and date below**
17. 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