USFHP Prior Authorization Request Form for

Anti Obesity Agents (phentermine, benzphetamine, diethylpropion, phendimetrazine IR and SR)

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/

Prior authorization does not expire. 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. What is the patient's body mass index (BMI)?	☐ Less than 27 – **STOP - Coverage not approved** ☐ 27 to 29 with an additional comorbidity – Proceed to Question **5** ☐ 30 to 34 – Proceed to Question **7** ☐ 35 to 39 – Proceed to Question **7** ☐ Greater than 40 – Proceed to Question **7**	
5. Does the patient have AT LEAST ONE weight-related comorbidity?	☐ Yes Proceed to question **6**	☐ No **STOP – Coverage not approved**

6. In addition to overweight with BMI GREATER THAN 27, what are the major condition(s)/comorbidities being treated (select all that apply)?	☐ Diabetes or impaired glucose tolerance ☐ Obstructive sleep apnea ☐ Osteoarthritis ☐ Metabolic syndrome ☐ Dyslipidemia ☐ Hypertension ☐ Metabolic dysfunction-associated steatohepatitis (MASH) ☐ Established cardiovascular disease with a history of stroke ☐ Established cardiovascular disease with a history of myocardial infarction ☐ Established cardiovascular disease with a history of peripheral artery disease _____ **Sign and date below**
7. What are the major condition(s)/comorbidities being treated (select all that apply)?	☐ Obesity ☐ Diabetes or impaired glucose tolerance ☐ Obstructive sleep apnea ☐ Osteoarthritis ☐ Metabolic syndrome ☐ Dyslipidemia ☐ Hypertension ☐ Metabolic dysfunction-associated steatohepatitis (MASH) ☐ Established cardiovascular disease with a history of stroke ☐ Established cardiovascular disease with a history of myocardial infarction ☐ Established cardiovascular disease with a history of peripheral artery disease _____ **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