US Family Health Plan
Prior Authorization Request Form for
phentermine/topiramate ER (Qsymia)

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 4 months, renewal is for 12 months. For renewal of therapy an initial USFHP 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 USFHP benefit in the last 6 months? *Please choose "No" if the patient did not previously have a USFHP approved PA for Qsymia*	☐ 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 generic phentermine?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Has the patient tried and failed to achieve a 5 percent reduction in baseline weight after a 12 week course of phentermine?	☐ 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 agent?	☐ 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**

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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. Will the prescriber abide by and has the patient been informed of the REMS and the following safety concerns associated this medication; Use in combination with other products intended for weight loss has not been established, Use in patients with increased cardiovascular risk has not been established, Qsymia is pregnancy category X and is associated with increased risk of teratogenicity?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Does the patient have impaired glucose tolerance or diabetes?	☐ Yes Proceed to question **13**	☐ No **Sign and date below**
13. Has the patient tried metformin first, or is concurrently taking metformin?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
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 5 percent of baseline body weight since starting medication?	☐ Yes Proceed to question **19**	☐ No **Proceed to question 16**
16. Is the patient currently receiving Qysmia at a dose of 7.5 mg / 46 mg daily?	☐ Yes Proceed to question **17**	☐ No **STOP** **Coverage not approved**
17. Has the patient lost GREATER THAN or EQUAL to 3 percent of baseline body weight since starting medication?	☐ Yes Proceed to question **18**	☐ No **STOP** **Coverage not approved**
18. Will the dose of Qsymia be escalated to 15 mg/ 92 mg?	☐ Yes Proceed to question **19**	☐ No **STOP** **Coverage not approved**

19. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **20**
20. Is the patient an Active Duty Service Member?	☐ Yes Proceed to question **21**	☐ No **Sign and date below**
21. 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