US Family Health Plan
Prior Authorization Request Form for
liraglutide 3 mg injection **(Saxenda),** semaglutide 2.4mg injection **(Wegovy)**

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 4 months, renewal approves for 12 months. For renewal of therapy an initial USFHP prior authorization approval is required. Medical documentation may be required. Failure to provide could result in denial.

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 the requested medication.*	☐ Yes (subject to verification) **Proceed to question 18**	☐ No **Proceed to question 2**
2. What is the requested medication?	☐ Saxenda - **Proceed to question 4** ☐ Wegovy - **Proceed to question 3**	
3. How old is the patient?	☐ Greater than or equal to 18 years of age - **Proceed to question 7** ☐ Less than 18 years of age - **STOP Coverage not approved**	
4. How old is the patient?	☐ Between 12 years of age and 15 years of age - **Proceed to question 11** ☐ Between 16 years of age and 17 years of age - **Proceed to question 5** ☐ Greater than or equal to 18 years of age - **Proceed to question 7** ☐ Less than 12 years of age - **STOP Coverage not approved**	
5. Has the patient tried and failed or has a contraindication to generic phentermine?	☐ Yes **Proceed to question 6**	☐ No **STOP Coverage not approved**

6. Please provide the date and duration or contraindication for each medication listed below.

Note: The dates and durations of therapy for each medication or contraindication to each medication listed below must be provided or your case could be denied.

Phentermine: Date_____ Duration of therapy _____ Contraindication _____

Proceed to question 11

7. Has the patient tried and failed or has a contraindication to ALL of the following agents: generic phentermine, Qsymia, Xenical, and Contrave?	☐ Yes **Proceed to question 8**	☐ No **STOP** **Coverage not approved**

8. Please provide the date and duration or contraindication for each medication listed below.

Note: The dates and durations of therapy for each medication or contraindication to each medication listed below must be provided or your case could be denied.

Phentermine: Date_____ Duration of therapy _____ Contraindication _____

Qsymia: Date _____ Duration of therapy _____ Contraindication _____

Xenical: Date _____ Duration of therapy _____ Contraindication _____

Contrave: Date _____ Duration of therapy _____ Contraindication _____

Proceed to question 9

9. Is the patient diabetic?	☐ Yes **Proceed to question 10**	☐ No **Proceed to question 11**
10. Has the patient tried and failed metformin and the preferred GLP1-RAs (Ozempic and Trulicity)?	☐ Yes **Proceed to question 11**	☐ No **STOP** **Coverage not approved**
11. Will the requested medication be used with another GLP1RA (for example, Bydureon, Trulicity, Byetta, Adlyxin, Victoza, Soliqua, Xultophy)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 12**
12. Does the patient have a history of or family history of medullary thyroid cancer, or multiple endocrine neoplasia syndrome type 2?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 13**
13. 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 14**	☐ No **STOP** **Coverage not approved**

14. 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 15**	☐ No **STOP** **Coverage not approved**
15. Is the patient an Active Duty Service Member?	☐ Yes **Proceed to question 16**	☐ No **Proceed to question 17**
16. 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 17**	☐ No **STOP** **Coverage not approved**
17. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
18. Is the patient currently engaged in behavioral modification and on a reduced calorie diet?	☐ Yes **Proceed to question 19**	☐ No **STOP** **Coverage not approved**
19. Has the patient lost GREATER THAN or EQUAL to 4 percent of baseline body weight since starting medication despite 16 weeks of therapy?	☐ Yes **Proceed to question 20**	☐ No **STOP** **Coverage not approved**
20. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 21**
21. Is the patient an Active Duty Service Member?	☐ Yes **Proceed to question 22**	☐ No **Sign and date below**
22. 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