US Family Health Plan
Prior Authorization Request Form for
orlistat (Xenical)

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 therapy approves 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. What is the patient's age?	☐ younger than 12 years of age **– STOP Coverage not approved** ☐ 12 to 17 years of age **– proceed to question 2** ☐ 18 years of age and older **- Proceed to question 3**	
2. 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 Xenical*	☐ Yes (subject to verification) **Proceed to question 23**	☐ No **Proceed to question 19**
3. 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 Xenical*	☐ Yes (subject to verification) **Proceed to question 14**	☐ No **Proceed to question 4**
4. Has the patient tried and failed or has a contraindication to ALL of the following: Qsymia and Contrave?	☐ Yes **Proceed to question 5**	☐ No **STOP** **Coverage not approved**
5. Has the patient tried and failed generic phentermine or does the patient have a contraindication to phentermine?	☐ Yes **Proceed to question 6**	☐ No **STOP** **Coverage not approved**
6. Does the patient have chronic malabsorption syndrome or cholestasis?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 7**

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7. 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 8**	☐ No **STOP** **Coverage not approved**
8. 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 9**	☐ No **STOP** **Coverage not approved**
9. Is the patient an Active Duty Service Member?	☐ Yes **Proceed to question 10**	☐ No **Proceed to question 11**
10. 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 11**	☐ No **STOP** **Coverage not approved**
11. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 12**
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 16**	☐ No **STOP** **Coverage not approved**
16. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 17**
17. Is the patient an Active Duty Service Member?	☐ Yes **Proceed to question 18**	☐ No **Sign and date below**
18. 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**

19. Does the patient currently have a BMI of GREATER THAN or EQUAL to the 95th percentile for age and sex, OR if in GREATER THAN or EQUAL to the 85th percentile but LESS THAN 95th percentile for age and sex and has at least one severe co-morbidity (type 2 diabetes mellitus, premature cardiovascular disease) or has a strong family history of diabetes or premature cardiovascular disease (CVD)?	☐ Yes **Proceed to question 20**	☐ No **STOP** **Coverage not approved**
20. Has the patient engaged in a trial of behavioral modification and dietary restriction for at least 3 months and has failed to achieve the desired weight loss, and will remain engaged throughout course of therapy?	☐ Yes **Proceed to question 21**	☐ No **STOP** **Coverage not approved**
21. Has the patient tried and failed generic phentermine or does the patient have a contraindication to phentermine?	☐ Yes **Proceed to question 22**	☐ No **STOP** **Coverage not approved**
22. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
23. Is the patient currently engaged in behavioral modification and on a reduced calorie diet?	☐ Yes **Proceed to question 24**	☐ No **STOP** **Coverage not approved**
24. Has the patient's current BMI percentile decreased for age and weight (considering the patient is increasing in height and will have a different normative BMI from when Xenical was started)?	☐ Yes **Proceed to question 26**	☐ No **Proceed to question 25**
25. Does the patient currently have a BMI GREATER THAN the 85th percentile?	☐ Yes **Proceed to question 26**	☐ No **STOP** **Coverage not approved**
26. 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