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Visit [go.covermymeds.com/OptumRx](http://go.covermymeds.com/OptumRx) to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

## Anorexiant Prior Authorization Request Form (Page 1 of 2)

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information <small>(required)</small>					
<p><b>Continuation of therapy:</b>            Is this a continuation of prior therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No            If "yes" to the above question, please submit documentation (e.g., medical records, chart notes, pharmacy claims) or provide the dates, duration, and previous regimen used below: <b>(REQUIRED)</b></p> <p>_____</p> <p>_____</p>					
<p><b>Select the diagnosis below:</b>  <input type="checkbox"/> Weight loss  <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>					
<p><b>Body Mass Index (BMI):</b>            Patient's current BMI: _____ Height: _____ Weight: _____</p>					
<p><b>Medication history:</b>  <b>Select the medications the patient has had a prior trial and failure of:</b>  <input type="checkbox"/> Belviq                      <input type="checkbox"/> Qsymia                      <input type="checkbox"/> Xenical</p> <p>Are there contraindications or absolute drug interactions with existing therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
<p><b>Clinical information:</b>  <b>Please document the following:</b></p> <p>1. Previous weight loss attempt with diet and exercise (lasting at least 12 weeks) and weight loss associated with that trial:            _____</p> <p>2. Goal of therapy and medication discontinuation plan: _____</p> <p>3. Diet and exercise counseling: _____</p> <p>4. Diet and exercise to be maintained throughout prescription therapy: _____</p> <p>5. Co-morbidities: _____</p>					

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**  
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## Anorexiant Prior Authorization Request Form (Page 2 of 2)

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.  
For urgent or expedited requests please call 1-800-711-4555.  
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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