

## Pharmacy Exception Review Request Form

**For a Fax request of Meridia®, Xenical®, or Phentermine (Not a Benefit for Part D)**

Please **Fax** completed Form to our  
 Pharmacy Services Department at  
**(505) 923-5540 or 1-800-724-6953.**

For help with this Form, please call  
 (505) 923-5757 or  
 toll-free 1-888-923-5757, option 3.

PROVIDER INFORMATION		MEMBER INFORMATION	
Prescriber's Name: _____		Member's Name: _____	
Contact Person: _____		Member's ID Number: _____	
Phone: _____	Fax: _____	Member's Date of Birth: _____	
Prescriber's Signature: _____			

MEDICATION REQUESTED
<input type="checkbox"/> Meridia 5mg Daily (>16 years) <input type="checkbox"/> Meridia 10mg Daily (>16 years) <input type="checkbox"/> Meridia 15mg Daily (>16 years) <input type="checkbox"/> Phentermine _____mg <input type="checkbox"/> Daily <input type="checkbox"/> Twice Daily (>16 years) <input type="checkbox"/> Xenical 120mg 3 times Daily (>12 years)

Please check the appropriate box to indicate if this request is for **Initial Coverage** or **Continuation of Current Coverage**. Please answer **all** questions in the Section you have selected.

**Initial Coverage** -- Criteria: BMI  $\geq$  27 and  $\geq$  2 Comorbidities, or BMI  $\geq$  30. Initial Coverage approvals are for one (1) month.

1. BMI \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Date \_\_\_\_\_

2. **Comorbidities** (Check all that apply)

Cardiomyopathy   
  Congestive Heart Failure   
  Obesity Related Hypertension (>140/90)  
 Established CHD   
  Obstructive Sleep Apnea   
  Diabetes: Last A1C: \_\_\_\_\_ Date: \_\_\_\_\_

3. Member will participate in the following supervised weight control program:

Regular Physician Visits                     
  Weight Watchers®, NutriSystem®, or a similar program  
 Nutritionist, Dietician                             
  Other (Please state): \_\_\_\_\_

4. History of patient's attempts to lose weight: \_\_\_\_\_

**Continuation of Current Coverage**

1. Previous BMI \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Date \_\_\_\_\_

2. Current BMI \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Date \_\_\_\_\_

**Continued Coverage after 1<sup>st</sup> Month**                                     
  **Continued Coverage after 3<sup>rd</sup> Month**  
 1. Member has lost >4 pounds of their initial body weight.                     
 1. Member has lost 5% of their initial body weight.  
 Approval for 2 additional months, if criteria met.                                     
 Approval for 3 months, if criteria met.

PHARMACY SERVICES DEPARTMENT USE ONLY			
Prior Authorization Number: _____	<input type="checkbox"/> APPROVED	<input type="checkbox"/> DENIED	<input type="checkbox"/> Commercial
RPH Review: _____	Date: _____		<input type="checkbox"/> Salud
Medical Director: _____	Date: _____		<input type="checkbox"/> NMRx
			<input type="checkbox"/> NMRx Wrap
Comments: _____			