

Pharmacy Exception Review Request Form
Request of Xenical[®], or Phentermine (Not a Benefit for Part D or Medicaid Plans)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"/> Phentermine _____mg (>16 years) <input type="checkbox"/> Daily <input type="checkbox"/> Twice Daily <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.			
<input type="checkbox"/> 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)			
<input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Obesity Related Hypertension (>140/90)			
<input type="checkbox"/> Established CHD <input type="checkbox"/> Obstructive Sleep Apnea <input type="checkbox"/> Diabetes: Last A1C: _____ Date: _____			
3. Member will participate in the following supervised weight control program:			
<input type="checkbox"/> Regular Physician Visits <input type="checkbox"/> Weight Watchers [®] , NutriSystem [®] , or a similar program			
<input type="checkbox"/> Nutritionist, Dietician <input type="checkbox"/> Other (Please state): _____			
4. History of patient's attempts to lose weight: _____			

<input type="checkbox"/> Continuation of Current Coverage			
1. Previous BMI _____ Weight _____ Height _____ Date _____			
2. Current BMI _____ Weight _____ Height _____ Date _____			
<input type="checkbox"/> Continued Coverage after 1st Month		<input type="checkbox"/> Continued Coverage after 3rd Month	
1. Member has lost >4 pounds of their initial body weight. Approval for 2 additional months, if criteria met.		1. Member has lost 5% of their initial body weight. Approval for 3 months, if criteria met.	
PHARMACY SERVICES DEPARTMENT USE ONLY			
Prior Authorization Number:		<input type="checkbox"/> APPROVED	<input type="checkbox"/> DENIED
Pharmacist:		Date:	
Medical Director:		Date:	
Comments:			

Confidential Protected Health Information Enclosed. Protected Health Information (PHI) is personal and sensitive information related to a person's health care. It is being delivered to you after appropriate authorization from the patient/member or under circumstances that do not require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient/member consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.