

**Health New England  
Medication Request Form  
Anorexiant**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

**Prior Authorization**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

**Instructions:**

This form is to be used by participating physicians and pharmacy providers to obtain coverage of anorexiant medications. Please complete this form and fax to MedMetrics Health Partners at (800) 550-9246. If you have any questions regarding this process, please contact MedMetrics clinical call center at (866) 209-1057.

**Medication Request Information (please complete each section of this form prior to transmittal):**

Patient Information (all required)			Physician Information (all required)	
<b>Patient Name:</b>			<b>Physician Name:</b>	
			<b>Specialty:</b>	
			<b>NPI #:</b>	
<b>Patient HNE ID#:</b>			<b>HNE Provider #:</b>	
<b>Patient Date of Birth:</b>			<b>DEA # (required):</b>	
<b>Allergies:</b>			<b>Area Code and Telephone #: (     )     -</b>	
<b>BMI</b>	<b>HT</b>	<b>WT</b>	<b>Area Code and Fax # (required): (     )     -</b>	

**Drug Information**

<b>Requested Drug (please circle) / Strength:</b>		<b>Xenical<sup>®</sup></b> (orlistat, non-formulary)	<b>Meridia<sup>®</sup></b> (sibutramine, non-formulary)
<b>Dose, directions and length of treatment (please be specific):</b>		<b>Quantity (per month):</b>	<b>Refills:</b>
<b>Physician signature:</b>		<b>Date:</b>	

***Check existing medical conditions:***

<input type="checkbox"/> CAD	<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Hepatic dysfunction
<input type="checkbox"/> Arrhythmias	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cholestasis
<input type="checkbox"/> Stroke	<input type="checkbox"/> Chronic malabsorption	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Renal dysfunction	<input type="checkbox"/> Other (please specify):

***Other Pertinent History (relative or pertaining to this request):***

Have underlying causes of obesity (e.g., hypothyroidism) been excluded? Explain:	YES	NO
Has the side effect profile of the prescribed medication been discussed with the patient?	YES	NO
Has the patient's medication profile been reviewed for potential drug interactions?	YES	NO
Is the patient currently on a reduced caloric diet with <30% of the total daily calories from fat?	YES	NO
Has the patient participated in a weight-loss support program for the past 3months?	YES	NO

***Renewal Authorization Criteria (Applies to Previously Approved Health New England Members):***

Does member have documented weight loss and continues to participate in a weight-loss program?	YES	NO
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Effective date: 6/11/06 (date of last review 4/14/2009)

