DisclosedRx
The Fiduciary and Fully Disclosed PBM®

PO Box 701
Washington, IN 47501
Phone: 480-561-6005
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Prior Authorization Request Form

Oral Weight Loss Medications

☐ Standard ☐ Urgent ☐ Reconsideration/Appeal

Patient Information

Patient Name: _____ DOB (mm/dd/yyyy): _____ Gender: _____

Address: _____ City: _____ State & Zip: _____

Cardholder ID: _____ Group #: _____ Relationship Code: _____

Phone Number: _____ Email address: _____

Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Address: _____ City: _____ State & Zip: _____

Office Contact: _____ Phone Number: _____ Fax Number: _____

Medication Information

Drug Name: _____ Strength: _____ Quantity: _____

Directions: _____ Day Supply: _____

Indicate Request Type: ☐ New Start ☐ Renewal Therapy Start Date (if applicable): _____

Diagnosis: _____ ICD 10 Code: _____

Prior Authorization Request Information

Supporting documentation (i.e., chart notes, labs, etc.) must be attached to avoid processing delays

For initial requests:

1. Please provide the baseline height, weight, and BMI (prior to any weight loss medications):
   Height: _____ Weight: _____ BMI: _____ Date: _____
2. Please provide the current height, weight, and BMI (within the past 3 months):
   Height: _____ Weight: _____ BMI: _____ Date: _____
3. Will the patient be taking any other medications in combination with the requested agent for the treatment of this diagnosis? If yes, please list: _____ ☐ Yes ☐ No
4. Does the patient have any FDA contraindications to the requested agent? ☐ Yes ☐ No
5. Has the patient participated in at least 6 months in a diet, exercise, and lifestyle modification program/plan immediately prior to this request? Please submit documentation. ☐ Yes ☐ No
6. For Contrave/Qsymia requests: Has the patient had an inadequate clinical response of at least 12 weeks, intolerance, or contraindication to ONE of the following sympathomimetic/stimulant medications (phentermine, benzphetamine, diethylpropion/ER, phendimetrazine)? If yes, please list below. ☐ Yes ☐ No

Please continue to the next page.

Patient Name:	DOB:

Drug Name/Strength:	Start Date:	End Date:	Outcome:

For Renewal Requests:

7. **Please provide the baseline height, weight, and BMI (prior to any weight loss medications):**
   Height: _____ Weight: _____ BMI: _____ Date: _____
8. **Please provide the current height, weight, and BMI (within the past 3 months):**
   Height: _____ Weight: _____ BMI: _____ Date: _____
9. **Has the patient achieved and maintained a weight loss of at least 5% from baseline?** ☐**Yes** ☐**No**
10. **Does the patient have any FDA contraindications to the requested agent?** ☐**Yes** ☐**No**

Prescriber Signature: _____ **Date**: _____

Authorized Agent's Name: _____

Please fax this request to 602-585-0588 or our secure email at care@disclosedrx.com
Mail Requests to: DisclosedRx Clinical Team
PO Box 701 Washington, IN 47501

Additional Comments/Notes: