Prior Authorization Form

Xenical

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Xenical .

Drug Name (select from list of drugs shown)
Xenical (orlistat)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the patient completed at least 6 months of therapy with the requested drug?	Y N
[If no, then skip to question 3.]	
2. Did the patient lose at least 5 percent of baseline body weight OR has the patient continued to maintain their initial 5 percent weight loss?	Y N
[No further questions.]	
3. Does the patient have a body mass index (BMI) greater than or equal to 30 kg per square meter?	Y N
[If is yes, then skip to question 5.]	

4.	Does the patient have a body mass index (BMI) greater than or equal to 27 kg per square meter AND has additional risk factors?	Y N
5.	Will the requested medication be used with a reduced calorie diet and increased physical activity?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date