# PRIOR AUTHORIZATION FORM
## Weight Management with GLP1s - Commercial

Unless otherwise indicated below, authorization quantities are limited to the manufacturer recommended dosage

SCRIPIUS
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P.O. Box 30192 Salt Lake City, UT 84130

**Complete online at www.selecthealth.org/pa or fax back to: 801-650-3279**
**For questions or clarifications, call: 800-442-3129**

| **Patient Information** | |
|---|---|
| Patient's Name: | Patient's Date of Birth: |
| Patient's ID: | Patient's Phone #: |
| Diagnosis Code(s): | |
| **Requesting Provider Information** | |
| Name: | Phone #: |
| NPI/DEA: | Fax #: |
| Address: | Supervising Physician (if requesting provider bills under a different provider) |
| | Name: |
| | NPI/DEA: |
| **Servicing Provider Information (if different than requesting provider)** | |
| Name of provider or facility: | Phone number: |
| NPI/DEA: | Address: |

| Drug Name and Strength: | Directions / SIG: |
|---|---|

Q1. Which medication is being requested?

- ☐ Benzphetamine
- ☐ Contrave (naltrexone/bupropion)
- ☐ Diethylpropion
- ☐ Orlistat
- ☐ Phendimetrazine
- ☐ Phentermine
- ☐ Qsymia (phentermine/topiramate)
- ☐ Saxenda (liraglutide)
- ☐ Xenical (orlistat)
- ☐ Wegovy
- ☐ Zepbound

Q2. Is this a Reauthorization request?

- ☐ Yes
- ☐ No

Q3. If yes, has the patient remained adherent to a reduced-calorie diet and increased physical activity?

| | |
|---|---|
| ☐ Yes | ☐ No |
| Q4. Has the patient achieved and maintained at least a 5% weight loss from baseline?<br>☐ Yes | ☐ No |
| Q5. Is this patient 18 years of age or older?<br>☐ Yes | ☐ No |
| Q6. Has the patient agreed to adhere to a reduced-calorie diet and increased physical activity?<br>☐ Yes | ☐ No |
| Q7. If this request is for Qysmia or Contrave, is the patient at least 18 years of age or older?<br>☐ Yes | ☐ No |
| Q8. If this request is for Saxenda or Wegovy is the patient at least 12 years of age or older?<br>☐ Yes | ☐ No |
| Q9. If this is a request for Wegovy for a pediatric patient: does the patient have an initial BMI in the 95th percentile or greater for their age and sex?<br>☐ Yes | ☐ No |
| Q10. If this is a request for Saxenda for a pediatric patient: does the patient have a body weight above 60 kg AND an initial BMI corresponding to 30 kg/m2 for adults (obese) by international cut-offs?<br>☐ Yes | ☐ No |
| Q11. For adult patients, is the patient's body mass index (BMI) greater than or equal to 30, or greater than or equal to 27 with comorbidities (e.g. hypertension, dyslipidemia, obstructive sleep apnea, or cardiovascular disease)?<br>☐ Yes | ☐ No |
| Q12. Additional comments | |

**This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-650-3279. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.**

Prescriber Signature

Date