Medication Prior Authorization Form
Fax to 1-866-240-8123

Contrave

Member Information:

Subscriber's ID Number			Subscriber's Group Number
Member's Name		Phone	Date of Birth
Address	City	State	Zip Code

Provider Information:

Physician's Name	NPI	Phone	Fax
Address	City	State	Zip Code
Suite / Building	Physician's Signature		Date

Medication Information:

Drug Name	Drug Strength	Requested Quantity	Requested Day Supply
			☐ 30 days ☐ 90 days ☐ Other: _____
Directions			
Diagnosis			

Clinical Information:

1. Will the member use Contrave in combination with a lifestyle modification program that encourages reduced calorie diet and increased physical activity (e.g., nutritional counseling, participation in a comprehensive weight management program)?

   ☐ **Yes** ☐ **No**

2. Please specify how long (in months) this member has actively participated in a lifestyle modification program that encourages both a reduced calorie diet and increased physical activity (e.g., nutritional counseling, participation in a comprehensive weight management program) **prior** to initiating therapy with Contrave:

   _____ **months**

   ***Please attach documentation to support the answers to questions 1 and 2. Acceptable forms of documentation are listed below. One from each category is required.**

   Diet
   - Provider chart notes detailing specific dietary adjustments and/or calorie deficit
   - Recurring receipts for a subscription to a lifestyle modification program, such as Noom, Weight Watchers, Vida, Lark, Signos, Wondr, Livongo, Omada, Newtopia, Virta, plan sponsored coaching programs such as My Weight Management Journey or Penn State Health obesity medicine institute (e.g., monthly, provided for each month)
   - Dietary log maintained by member detailing specific diet and/or calorie deficit
   - Recurring appointments for private nutritional counseling or medical nutrition therapy (e.g., receipt or chart documentation provided monthly)

   Physical Activity
   - Provider chart notes specifying type, duration, and frequency of physical activity
   - Recurring receipts for a gym membership (e.g., monthly, provided for each month) and notes specifying type, duration, and frequency of physical activity
   - Summary report from a wearable device specifying frequency of physical activity (e.g., elevated heart rate for over 20 minutes for at least 3 times a week for a month)
   - Recurring appointments with a personal trainer (e.g., receipt provided monthly) and notes specifying type, duration, and frequency of physical activity)

3. Please list any weight-related comorbidities this member has, if applicable:
   ***Please attach documentation (e.g., chart notes) to support this information.**

   _____

   _____

4. Please provide any other medications that the member has tried and failed with dates of therapy, if applicable:

Previous weight loss medications (e.g. Saxenda, Qsymia, Wegovy, Xenical, Zepbound, previous Contrave therapy, etc)	**Dates of therapy**

5. Please provide the member's **baseline** (prior to therapy with Contrave or any other current weight loss medication):

Height: _____ Weight: _____ Body Mass Index: _____

***Please attach documentation (e.g., chart notes) to support above information.**

6. Only fill out this section for members currently on a weight loss medication.

- Which weight loss medication is the member currently taking? _____
- How long has the member been on this medication? _____
- Please provide the member's **current** (while on therapy with Contrave or other weight loss medication):

Height: _____ Weight: _____ Body Mass Index: _____

***Please attach documentation (e.g., chart notes) to support above information.**

The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the member. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Please print, type or write legibly in blue or black ink.
3. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
4. Please provide the physician address as it is required for physician notification.
5. Fax the **completed** form and all clinical documentation to **1-866-240-8123**
   Or mail the form to: **120 Fifth Avenue, SPECARE, Pittsburgh, PA 15222**

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