

# Pharmacy Prior Authorization Form

Last Reviewed: Sept. 11

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to:  Commercial Plan  Medicaid Plan  Medicare Plan

## Xenical (orlistat)

Urgent

Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Products:

Xenical 120 mg capsules

Dose: \_\_\_\_\_ Start date: \_\_\_\_\_

### Priority Health precertification requirements:

#### Authorization for Xenical requires:

- BMI greater than 35
- Age at least 21 years
- No known contraindications to using a reversible lipase inhibitor (e.g. malabsorption syndromes, cholestasis, pregnancy and/or lactation, known hypersensitivity to orlistat or any component of the product)
- Confirmed clinical failure with previous weight loss attempts
- BMI 35-40 requires poorly controlled diabetes and one of the following severe, obesity-related comorbidities:
  - Symptomatic sleep apnea (A/H index > 10)
  - Significant cardiac disease
  - Restrictive lung disease
  - Poorly controlled hypertension
  - Uncontrolled hyperlipidemia
- BMI > 40 requires one of the following severe, obesity-related comorbidities:
  - Symptomatic sleep apnea (A/H index > 10)
  - Significant cardiac disease
  - Restrictive lung disease
  - Poorly controlled hypertension
  - Uncontrolled hyperlipidemia
  - Uncontrolled diabetes mellitus
- Length of authorization if criteria are met:
  - 15 days on initial request
  - 15 additional days if drug tolerated
  - 90 additional days on refills if criteria continue to be met

#### Continuation of Xenical requires:

- 3% of the total original body weight at 3 months
- 5% of the total original body weight at 6 months
- 10% of the total original body weight at 12 months

**Please Complete the Following Information:**

Height: \_\_\_\_\_

Current Weight: \_\_\_\_\_

Patient's BMI: \_\_\_\_\_

Patient's age: \_\_\_\_\_

New request or continuation of therapy:

- New
- Continuation (please complete the continuation section)

Patient has at least one of the following contraindications to using a reversible lipase inhibitor:

- Yes – Rationale for use: \_\_\_\_\_
  - malabsorption syndromes
  - Cholestasis
  - pregnancy and/or lactation
  - known hypersensitivity to orlistat or any component of the product
- No

Patient has had confirmed clinical failure with previous weight loss attempts:

- Yes – Please provide details of previous weight loss attempts and clinical reason for failure:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- No – Rationale for use: \_\_\_\_\_

Patient has at least one of the following obesity-related comorbidities:

- Yes
  - Symptomatic sleep apnea (A/H index > 10)
  - Significant cardiac disease
  - Restrictive lung disease
  - Poorly controlled hypertension
  - Uncontrolled hyperlipidemia
  - Poorly controlled diabetes
- No

To support the diagnoses above, please provide the following patient information if applicable to the co-morbid conditions checked above:

Blood Pressure: \_\_\_\_\_ Date: \_\_\_\_\_

Total Cholesterol: \_\_\_\_\_ Date: \_\_\_\_\_

LDL-Cholesterol: \_\_\_\_\_ Date: \_\_\_\_\_

HDL-Cholesterol: \_\_\_\_\_ Date: \_\_\_\_\_

Triglycerides: \_\_\_\_\_ Date: \_\_\_\_\_

A1C: \_\_\_\_\_ Date: \_\_\_\_\_

A/H index: \_\_\_\_\_ Date: \_\_\_\_\_

List current pharmacologic therapy for co-morbid conditions checked in (2) above, including medication name, dosage and directions for use:

---

---

---

---

---

---

---

**Continuation Section:**

How long has the patient been on therapy? \_\_\_\_\_

What is the percentage of total weight loss? \_\_\_\_\_

Baseline weight: \_\_\_\_\_

Current weight: \_\_\_\_\_

\*\*\* All fields must be complete and legible for Prior Authorization Review\*\*\*

**Please fax this request to: (877)974-4411 toll free or (616)942-8206  
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**