SCRIPTGUIDERX REQUEST FOR PRIOR AUTHORIZATION
ANTI OBESITY DRUGS

Prescribing Physician:

Name:_________________________________
First Last
Direct Phone #: (____) ___________________

Fax #: (_____)____________________________

Physician specialty: _____________________

Patient:

Name:____
First Last
ID#: ____

Phone #: ______________________Group:__________

Birth Date: _ _ - _ _ - _ _ _ _ Sex: ☐ Female ☐ Male

Name and title of person completing form (please print): _______________________________________

Drug name: **Strength:** **Administration Schedule:** **Length of Therapy:** **Quantity Requested:**

Has patient been on this drug and, if yes, for how long at this dosage? _______________________________

Patient's diagnosis requiring the use of this medication: ____

*****This information is required*****

Patient's: Height: ________ Weight:_________ Target Weight:_________

If this is a re-authorization please note patient's weight prior to starting this medication: _____________

What life style modification plan is the patient on?____

RISK Factors: (check all that apply) ___Hypertension ___Coronary Artery Disease

____Congestive Heart Failure ____Diabetes Mellitus ____No Risk Factors

What other weight loss programs have been tried? ____

____

Previous non-prior authorized and prior authorized medications tried and failed for this condition:

Name of medication	Reason for failure	Date:
___________________________	_____________________________________	_ _/ _ _/ _ _ _ _
___________________________	_____________________________________	_ _/ _ _/ _ _ _ _
___________________________	_____________________________________	_ _/ _ _/ _ _ _ _

Other Information: ____

Fax Request to: ScriptGuideRX @ 313-264-0985

For ScriptGuideRX use only

Date Received:

Date Completed:

Decision (all authorizations are pending valid eligibility):

15400 E. Jefferson Avenue ♦ Grosse Pointe Park ♦ MI ♦ 48230 ♦ 313-499-3223 ext 207
www.scriptguiderx.com