Xenical® (orlistat)
Prior Authorization Form

ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

Complete Patient and Physician information (PLEASE PRINT)

STEP 1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:
	Tax ID or NPI #:

If Applicable: Pharmacy Name: ____
Pharmacy Phone: ____

Complete the Clinical Assessment:

STEP 2

Diagnosis	☐ Diabetes ☐ Anorexia ☐ Hyperlipidemia ☐ Bulemia ☐ Hypertension ☐ Other (please state): ______________________ ☐ Obstructive sleep apnea Initial prior authorization will be for 3 months if the drug is tolerated. Each subsequent prior authorization will be limited to 6 months. **Requests are considered for Medicaid members only. Requests will be denied for all other lines of business and if the patient has a diagnosis of Anorexia or Bulimia.**
Clinical Consideration	☐ Body mass index (BMI) greater than or equal to 30? ___________________________ ☐ First time Xenical has been requested for this member? ________________________ ☐ 2nd or subsequent PA request for Xenical, has the patient lost at least 3% body weight per month?
Supporting Documentation	Diagnosis: ICD-9/10 Code #/ Description / J Code (required):
	Please attach a copy of the prescription or provide ALL of the information below: Xenical® (orlistat) Strength ____ Sig ____ Qty ____ Refills
	Please attach all relevant medical records and test results **We will not process incomplete forms.** **If we do not receive the completed form & all relevant medical records & test results within 10 calendar days of this request, it will be denied.**

STEP 3

I certify that the above is correct and accurate to the best of my knowledge and that the form is complete. (please sign and date)

____ ________________________
Prescriber Signature Date

STEP 4

Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:

970-248-5034

Name of Person filling out form: ____

Pharmacy Technician initials ______Date Initiated _________________________

Confidentiality Notice:

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