QUEST Anti-Obesity Agents
Drug Coverage Request Form
Pharmacy Services Fax #: 973-6327, Toll-Free Fax (877)-316-6376

MEMBER INFORMATION

Name:	Member ID #:	D.O.B.:

PROVIDER INFORMATION

Prescribing Provider Name:		Specialty:
Office Contact Person:	Phone #:	Fax #:

Reason for Request & Requirements for Determination

☐ Standard - 14 Calendar Days

☐ Expedited * (72 Hours)

Reason: ______________________________

*** Expedited review is reserved for life threatning or medically necessary requests. Provide reason for expedited review above.**

INDICATE or PROVIDE

☐ Drug Name **: ______________________________ ☐ Strength: ______________

**Please note for all Xenical requests: unless there is medical reasoning supporting the use of Xenical, we will automatically consider Alii.

☐ Directions: ______________________________ Quantity: __________ Refills: __________

☐ Height: __________ ' __________ " Current Weight: __________ pounds BMI: __________

In the past 6 months, has the member been on a: (*please check all that apply*)

☐ Portion Size diet? ☐ Exercise Program? ☐ Behavior Therapy?

☐ Is the member enrolled in a support program? If yes, where: ______________________________

Co-morbid conditions present: (*please check all that apply*)

☐ Hypertension ☐ Diabetes ☐ Sleep Apnea ☐ CHD ☐ Dyslipidema

☐ Other pertinent condition: ______________________________

☐ BP: __________ HDL: __________ LDL: __________ TG: __________ HgbA1C: __________

☐ Current Medications: ______________________________

☐ FOR REFILL REQUESTS: *(indicate monthly blood pressure and weight levels)* ______________________________

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Provider Signature: ______________________________ Date: __________

FOR ALOHACARE USE ONLY:

☐ **APPROVED** Date Approved: __________ Through: __________ # of Refills: __________

☐ **NOT APPROVED**** Date Denied: __________ Time: __________ Reason:** ______________________________

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Reviewer: ______________________________ Date: __________