THE OHIO STATE UNIVERSITY
HEALTH PLAN

Weight Loss Medication Authorization Form

Email completed form with required documentation to:
UtilizationManagement.OSUHealthPlan@osumc.edu **or fax to: (614) 292-2667**

Patient Information

Patient Name:	
Patient DOB:	Phone #:
Insurance ID #:	

Requesting Provider Information

Physician Name:	
Office Contact Name:	
Phone #:	Secure Fax#:

1. Requested weight loss medication: ___ Contrave® ___ Saxenda® *Note: Qsymia® is an excluded medication and is not covered by the health plan.*
2. CURRENT height: _____ cm, weight: _____ kg, AND body mass index (BMI): _____ kg/m^2
3. Diagnosed co-morbid conditions: ___ Type 2 Diabetes ___ Cardiovascular Disease ___ Hypertension
   ___ Dyslipidemia ___ Obstructive Sleep Apnea
4. Specify INITIAL or CONTINUED medication coverage and include ALL requested information.

____ INITIAL MEDICATION COVERAGE:

A) Attach chart documentation describing patient's specific diet and exercise regimen. Documentation must account for a 6-month period prior to request for weight loss medication initiation.

B) List any previous or current weight loss medications — Start Date — End Date

_____ _____ _____
_____ _____ _____
_____ _____ _____

C) List (or attach) ALL weight (kg) measurements within the past 12 MONTHS:

Date:	kg:	Date:	kg:	Date:	kg:	Date:	kg:
Date:	kg:	Date:	kg:	Date:	kg:	Date:	kg:
Date:	kg:	Date:	kg:	Date:	kg:	Date:	kg:

____ CONTINUED MEDICATION COVERAGE:

A) List (or attach) ALL weight (kg) measurements within the past 6 MONTHS (since most recent drug approval):

Date:	kg:	Date:	kg:	Date:	kg:	Date:	kg:
Date:	kg:	Date:	kg:	Date:	kg:	Date:	kg:
Date:	kg:	Date:	kg:	Date:	kg:	Date:	kg:

Requesting Physician Signature: _____ Date: _____

For questions, please contact the OSU Health Plan at (614) 292-4700

OSU Health Plan USE ONLY

Date: _____ Authorization #: _____ Dates of Service: _____to_____

OSU Health Plan Contact: _____ Contact Phone: _____

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