

**Blue Cross and Blue Shield of Vermont and The Vermont Health Plan
Prior Authorization Form
Meridia® (sibutramine)
BCBSVT and TVHP Fax # (888)–255-1006**

If approval criteria are met, BCBSVT/TVHP will authorize coverage of Meridia® (sibutramine).
Thank you for your assistance.

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request _____ Patient Name: _____
 BCBSVT/TVHP Member ID#: _____ Date of birth: _____
 Provider Name: _____ Provider Phone number: _____
 Provider Fax number: _____ PCP Name: _____
 Patient weight: _____ Patient height: _____

INDICATIONS FOR USE: *(if this is a renewal proceed to question 5)*

	<u>YES</u>	<u>NO</u>
1. Patient remains overweight despite weight reduction program including dietary modification and increased physical activity.	<input type="checkbox"/>	<input type="checkbox"/>
2. Patient is enrolled in nutritional counseling.	<input type="checkbox"/>	<input type="checkbox"/>
3. Patient is 16 years of age or older.	<input type="checkbox"/>	<input type="checkbox"/>
4. Patient's initial body mass index (BMI) is $\geq 30 \text{ kg/m}^2$ OR Patient's initial body mass index (BMI) is $\geq 27 \text{ kg/m}^2$ and patient has at least two of the following cardiovascular risk factors: diabetes, dyslipidemia, hypertension.	<input type="checkbox"/>	<input type="checkbox"/>
5. If this is a renewal after first 3 months of therapy: Has the patient lost at least 10 lbs. or 5% of body weight since initiation of Meridia®? If this is a renewal after > 6 months of therapy: Has the patient lost at least 6 lbs. or 5% of body weight in the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>

REASONS FOR DENIAL OF BENEFIT:

	<u>YES</u>	<u>NO</u>
1. Patient has a known hypersensitivity to Meridia® or any of its components.	<input type="checkbox"/>	<input type="checkbox"/>
2. Patient has a history of coronary artery disease, congestive heart failure, arrhythmias or stroke.	<input type="checkbox"/>	<input type="checkbox"/>
3. Patient has uncontrolled hypertension.	<input type="checkbox"/>	<input type="checkbox"/>
4. Patient is receiving a monoamine oxidase inhibitor (MAOI).	<input type="checkbox"/>	<input type="checkbox"/>
5. Patient has a major eating disorder (anorexia nervosa or bulimia nervosa).	<input type="checkbox"/>	<input type="checkbox"/>
6. Patient is taking an amphetamine product or another centrally-acting weight loss agent.	<input type="checkbox"/>	<input type="checkbox"/>

If patient meets criteria: Initial approval: 3 months Quantity limit: 30caps/30days Renewal approval: 6 months

Dose: _____ Frequency: _____ Duration of Therapy: _____

PRESCRIBER SIGNATURE _____ DATE _____

By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.