

MICHIGAN
Department Of Community Health Pharmacy Program
Prior Authorization Request
XENICAL® (ORLISTAT)

All information on this form must be addressed. Incomplete forms will be returned once for missing information. Mark as 'N/A' if no information is available or does not apply. Issues that remain blank after being returned once, will receive a denial and will not qualify for MDCH physician review until completed.

Prescribing Physician:

Beneficiary:

Male Female

Name: _____

Name: _____

First Last

First Last

Phone #: _____

Medicaid #: _____

Fax #: _____

Date of Birth: _____

NPI: _____

Specialty: _____

NPI accepted as of April 17, 2007

Person completing form: _____ Rqstd start date: _____

Name

Title

Date

Pharmacy: _____

Phone #: _____

Drug Name	Strength	Dose	Duration of Rx
XENICAL	120mg		

Results of a medical history and physical exam as well as nutritional or dietetic assessment: _____

Has the beneficiary seen any other provider for this condition? Yes No If "Yes", what was the provider's specialty and findings?

Other diagnoses & list of current medications: _____

Current Body Mass Index (BMI): _____ Height: _____ Current Weight: _____

Are there any contraindications for this use, malabsorption syndromes, cholestasis, pregnancy and/or lactation?

Is this part of a total treatment plan including a calorie and fat restricted diet & exercise regimen? _____

If "YES", please attach copy of plan.

Have there been at least 2 prior weight loss plans or programs including diet & exercise regimens? _____

If "YES", please attach copies and reason(s) for failures.

Additional comments: _____

Submit requests to: First Health Services, MAP Department, 4300 Cox Road, Glen Allen, VA 23060

Fax: 888-603-7696 Phone: 877-864-9014

This form is available at www.michigan.fhsc.com -> Providers -> Forms