

FAX TO : 1-800-459-2135

Health Information Designs, Inc.
P.O. Box 320506
Flowood, MS 39232
Phone 800-355-0486

XENICAL (ORLISTAT)
PRIOR AUTHORIZATION REQUEST FORM

BENEFICIARY INFORMATION

Beneficiary's Name: _____ Beneficiary's Medicaid # _____

DOB: _____ City _____
Month Day 4-Digit Year

PRESCRIBER INFORMATION

Prescribing Physician: _____

City _____ State _____

NPI #: _____

Medicaid ID # _____

Phone #: _____

FAX #: _____

A physician, nurse practitioner or physician assistant who attests to the medical necessity of the prescribed medication, who knowingly or willingly makes, or causes to be made, any false statement or representation of a fact in any application for Medicaid benefits or payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to a civil monetary penalties and/or fines. I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem them medically necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

Physician's signature and date

PHARMACY INFORMATION

Dispensing Pharmacy: _____

City _____ State _____

Provider # _____

Phone #: _____

FAX #: _____

DRUG/CLINICAL INFORMATION

Drug Name: _____ Quantity /Month _____ Daily Dose: _____ mg/day

Diagnosis: _____ NDC#: _____

Additional Medical Justification: _____

List failed therapy or contraindication to one product in each of the following categories:

- 1. Niacin Product _____
- 2. Fibric Acid derivative _____
- 3. Bile Acid sequestrant _____
- 4. HMG Co-A reductase inhibitor _____

Beneficiary has any of the following:

Chronic malabsorption syndrome	Y	N
Hypothyroidism	Y	N
Cholestasis	Y	N
Hypersensitivity to Xenical	Y	N
Currently on other lipid-lowering agent	Y	N
< 21 year of age	Y	N

***** Must submit copy of lab results within the past 30 day period with request*****

FOR HID USE ONLY

Eligibility Verified by _____

Approved _____

Denied/Code: _____

From Date _____ Thru Date _____

Reviewed by _____

HID# _____ PA# _____