

TeamstersCare Weight Loss Agents Prior Authorization Form



- ❖ Complete and fax to 617-241-5025.
- ❖ Standard response time is 3 to 5 business days from date received.

PATIENT INFORMATION	
Patient Name:	
Date of Birth:	TeamstersCare ID#:
Patient Address:	Patient Phone:
PROVIDER INFORMATION	
Provider Name:	
Contact Person (If different than prescriber):	
Office Phone:	Office Fax:
MEDICATION INFORMATION	
Medication Requested: (specify name, strength, dosing)	
Diagnosis Related to Use:	
Significant Comorbidities:	
Other Alternatives Tried and Failed:	
Current Height and Weight:	
Previous Weights with Dates:	
Doctor's Signature:	Date:

FOR TEAMSTERCARE USE ONLY	
Eligibility Verified <input type="checkbox"/>	Notes:
Program: Active <input type="checkbox"/> ERMP <input type="checkbox"/> RRX <input type="checkbox"/>	
Prior PA? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Date:	
Form Complete/Legible <input type="checkbox"/>	
Authorized <input type="checkbox"/> Pended <input type="checkbox"/> Denied <input type="checkbox"/>	
Patient Notified <input type="checkbox"/> By: Date:	
Letter Sent <input type="checkbox"/> By: Date:	
Reviewer :	Date: