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:_____ Weight:_____ BMI:_____ Weight Goal:_____ Previous Weights with Dates: Please send a copy of most recent office visit notes	Bariatric surgery? Yes☐ No ☐ If Yes, Pre-surgery weight:_____ Date:_____ Weight Accomplished:_____ Date:_____
Doctor's Signature:	**Date:**

FOR TEAMSTERSCARE USE ONLY	
Eligibility Verified ☐	**Notes:**
Active ☐ ERMP ☐ RRX☐	
Prior PA? Yes☐ No ☐ If Yes, Date(s):_____ _____ _____ _____ _____	
Form Complete/Legible ☐	
Patient Notified ☐ By:	**Reviewer :** **Date:**

Rev 05-2023