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:	
Office Phone:	Office Fax:
MEDICATION INFORMATION	
Medication Requested: (specify name, strength, dosing)	
Diagnosis Related to Use:	
Significant Comorbidities:	
Other Alternatives Tried and Failed: If Bariatric surgery, Date____________________ PreOp weight_____________	
Current Weight (past month):_____________ Date Weighed _____________ Height ______________ BMI ____________ Previous Weights with Dates: **Please send a copy of most recent office visit notes**	
SIGNATURE	
Provider'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:**

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