

1. REQUEST TYPE AND INSTRUCTIONS

Select requested service:

QuickCheck[™]: Cost and coverage information in ~4 hours

Benefit Investigation: Cost and coverage information communicated to you and your patient plus additional patient support. Additional support may include PA/ appeal assistance and enrollment into copay/weight management programs for eligible patients.

Complete the required sections and fax the form to 844-667-3475.

2. PATIENT INFORMATION (Please print)

Patient Name: _____ Date of Birth: / / Gender: M F
 Address: _____ City: _____ State: ZIP: _____
 Home Phone: _____ Cell Phone: _____

3. PRESCRIPTION INSURANCE INFORMATION (Please provide a copy of front and back of patient's prescription insurance card or fill out section below)

PRIMARY PRESCRIPTION COVERAGE		SECONDARY PRESCRIPTION COVERAGE (If applicable)	
Insurance Name:	_____	Insurance Name:	_____
Insurance Phone #:	_____	Insurance Phone #:	_____
Member ID #:	_____	Member ID #:	_____
Employer:	_____	Employer:	_____

4. DIAGNOSIS AND CLINICAL INFORMATION (Not required for QuickCheck[™] requests)

Is this request for initiation or continuation of therapy? Initiation Continuation
Saxenda[®] (liraglutide) injection 3 mg (NDC: 0169-2800-15): Dose: _____ Frequency: _____ Quantity: _____ day(s) supply
 Primary Diagnosis Code: E66.9 E66.01 E66.09 R63.5 E66.3 Other (please specify): _____
 Current patient weight: _____ Height: _____ Current patient BMI: _____
 Does the patient have a comorbid condition? Dyslipidemia Hypertension Type 2 Diabetes Other
 Has patient previously received prescription weight management medication? Yes No
 Adipex-P[®] (Phentermine) Belviiq[®] (Lorcaserin) Contrave[®] (Bupropion) Qsymia[®] (Phentermine-topiramate) Xenical[®]/Alli[®] (Orlistat)
 Tenuate[®] (Diethylpropion) Didrex[®] (Bensphetamine) Other (please specify): _____
 Start date of weight management medication: / / Failed date of weight management medication: / /
 Is the patient unable to take stimulant weight loss medication? Yes No
 Does patient currently have any of the following: Concurrent use of other weight-loss products Pregnancy
 If this request is for a refill prescription, the % of patient weight loss within past 16 weeks:
 Document lifestyle modification, (if applicable): Caloric Restriction Exercise Other (please specify): _____

5. PRESCRIBER/FACILITY INFORMATION (Please ensure all ID#s correspond to the PRESCRIBER)

Prescriber Name: _____
 NPI #: _____ License #: _____
 Facility Name: _____ Tax ID: _____
 Address: _____ City: _____ State: ZIP: _____
 Phone: _____ Office Contact: _____
 Preferred method of contact: Email: _____ Fax: _____

PRESCRIBER CERTIFICATION

My signature certifies that I am a licensed practitioner under state law, that the above therapy is medically necessary, and that the information provided is accurate to the best of my knowledge. I further acknowledge that I have obtained the patient's authorization to release the above information as required by applicable privacy laws, including but not limited to, the Health Insurance Portability and Accountability Act ("HIPAA"), 42 U.S.C. § 1320 et seq., as well as such other information that may be required for RxCrossroads, LLC, acting on behalf of Novo Nordisk Inc. (collectively, "NovoCare[®] for Saxenda[®]"), to assist in obtaining co-pay/coverage information, coverage for Saxenda[®], and to assist in initiating or continuing therapy.

If your patient's plan requires a prior authorization (PA) or accepts appeals, do you authorize NovoCare[®] for Saxenda[®] to use the information provided on this form to complete and submit the PA or appeal on behalf of the patient? If you select, "Yes," you must complete section 4 and select the "Benefit Investigation" option in section 1.

Yes No

 **Prescriber's Signature:** _____ **Date:** _____