Obesity Referral Form (SC Therapies)

PHONE: 888-412-9325 FAX: 877-329-9325 eRx NPI: 1093424905 www.zealsp.com

Zeal Specialty Pharmacy

Remove above portion before faxing. Please complete the form in its entirety and fax with requested clinicals to the number above.

PNH24-01

PATIENT INFORMATION

Last Name	First Name	Date of Birth ____ /____ / ____	Gender ☐ Male ☐ Female
Address	City	State	Zip
email	Home Phone	Work Phone	Cell Phone

PRESCRIBER INFORMATION

Prescriber Full Name		Prescriber Credential	
Practice Address	City	State	Zip
Office email	Office Phone	Office Fax	Cell Phone
Practice Contact Person	Prescriber NPI	Preferred Contact Method ☐ Email ☐ Phone ☐ Fax	

CLINICAL INFORMATION – *please include any relevant office visit/lab notes*

Patient New to Therapy ☐ Naïve / New Start ☐ Therapy Restart ☐ Existing Treatment	Therapy Start Date ____ /____ / ____
Height _____ in Weight _____ lb Date ____ /____ / ____	Allergies ☐ NKDA ☐ Drug Allergies (please list)
Therapies Tried and Failed (please list name and dose)	
Concomitant Medications (please list name and dose)	
ICD-10 Code ☐ E66.0 Obesity due to excess calories	☐ E66._____
☐ E66.8 Other obesity	☐ Other _____

PRESCRIPTION – *please check all boxes across row*

Medication	Dose/Strength	Directions	Quantity	Refill
☐ **SAXENDA® (liraglutide)**	☐ 18 mg/3 mL	Subcutaneous **Not currently on Saxenda** ☐ Inject 0.6 mg SUBQ once daily for week 1; increase by 0.6 mg daily at weekly intervals to a target dose of 3 mg once daily. **Maintenance** ☐ Inject ____ (Dose) mg SUBQ once daily	☐ 5 syringes ☐ 10 syringes ☐ 15 syringes	☐ 1-year ☐ _____
☐ **WEGOVY® (semaglutide)**	☐ 0.5 mg/0.5 mL ☐ 1.7 mg/0.75 mL ☐ 2.4 mg/0.75 mL solution in a single-dose prefilled pen	Subcutaneous **Not currently on Wegovy or Ozempic** ☐ Inject 0.25 mg SUBQ once weekly, weeks 1-4 **Maintenance (preferred dosage)** ☐ Inject 2.4 mg SUBQ once weekly **Maintenance (with tolerance issue)** ☐ Inject 1.7 mg SUBQ once weekly	☐ 4 syringes ☐ 8 syringes ☐ 12 syringes	☐ 1-year ☐ _____
☐ **ZEPBOUND® (tirzepatide)**	☐ 2.5 mg/ 0.25 mL ☐ 5 mg/0.5 mL ☐ 7.5 mg/0.5 mL ☐ 10 mg/0.5 mL ☐ 12.5 mg/0.5 mL ☐ 15 mg/0.5 mL	Subcutaneous **Not currently on Wegovy or Ozempic** ☐ Inject 2.5 mg SUBQ once weekly for 4 weeks, then increase to 5 mg once weekly **Maintenance** ☐ Inject 5 mg SUBQ once weekly **Maintenance (higher dosage required)*** ☐ Inject ____ (Dose) mg SUBQ once weekly **Max dosage is 15 mg per week*	☐ 4 syringes ☐ 8 syringes ☐ 12 syringes	☐ 1-year ☐ _____

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: _____ ☐ MD ☐ DO ☐ PA. ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with all state-specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state-specific requirements could result in outreach to the prescriber.*

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic	Date Shipment Needed By: ____ /____ / ____