



Date _____

Customer _____

PRIOR AUTHORIZATION QUESTIONNAIRE- ANTI-OBESITY

M.D. Last Name: _____	M.D. First Name: _____
Physician Phone: _____	Physician Fax: _____
Patient _____	ID# _____ DOB _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

1. Please check the box of the drug being requested:

- | | |
|---|--|
| <input type="checkbox"/> *Meridia (sibutramine) | <input type="checkbox"/> Benzphetamine |
| <input type="checkbox"/> *Xenical (orlistat) | <input type="checkbox"/> Phendimetrazine |
| <input type="checkbox"/> Diethylpropion | <input type="checkbox"/> Phentermine |
| <input type="checkbox"/> Methamphetamine | <input type="checkbox"/> Phentermine resin |
| <input type="checkbox"/> Other _____ | |

*products marked with an asterisk have an FDA-indication for long-term use.

If OTHER, please attach a study showing safety and efficacy data to support the use of this product

2. Please list the strength and dosage form requested: _____

3. Please list the quantity requested and length of therapy: _____

4. Please list the patient's current weight: _____ LBS/KG Height: _____ IN//CM

5. Please check if patient has or if any of the following apply (SKIP if this request is for Xenical):

- | | |
|--|---|
| <input type="checkbox"/> Advanced arteriosclerosis | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Is Agitated |
| <input type="checkbox"/> Moderate-to-severe hypertension | <input type="checkbox"/> History of drug abuse |
| <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Taking another CNS Stimulant |
| <input type="checkbox"/> Patient has used an MAOI within 14 days | <input type="checkbox"/> Known hypersensitivity to sympathetic amines |

6. FOR MERIDIA ONLY-- Does the patient have a major eating disorder (anorexia/bulimia)? Yes No

7. FOR DIDREX ONLY-- Is the patient pregnant, or can the patient become pregnant? Yes No

8. FOR XENICAL ONLY-- Does the patient have chronic malabsorption syndrome or cholestasis? Yes No

Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

RESTAT
P.O. BOX 758
WEST BEND, WI 53095
www.restat.com

QUESTIONS PLEASE CALL:
877-526-9906