Saxenda® Enrollment Form

PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____ / _____ / _____ ☐ Male ☐ Female
SSN: _____ - _____ - _____
Address: _____
City: _____ State: _____ Zip: _____

Phone: (_____) - _____ - _____
Email: _____
Preferred method of contact: ☐ Phone ☐ Email
Height: _____ in Weight: _____ lb Date: _____ / _____ / _____
Allergies: Medications: (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact: _____ Clinic/Hospital Affiliation: _____

Phone: (_____) - _____ - _____ Fax: (_____) - _____ - _____
License #: _____
NPI #: _____
Medicaid Provider #: _____

SXRX-20-01

CLINICAL CONSIDERATIONS

Diagnosis: _____
ICD10: _____

History of therapies tried/failed (please include dates):

Immunization History
☐ Influenza
Date: ____ /____ / ____

℞

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **Saxenda®** (liraglutide)	☐ 18 mg/3 mL multi-dose pen	**Initial:** ☐ Inject 0.6 mg subcutaneously once daily x 7 days (week 1), then inject 1.2 mg subcutaneously once daily x 7 days (week 2), then inject 1.8 mg subcutaneously once daily x 7 days (week 3), then inject 2.4 mg subcutaneously once daily x 7 days (week 4), then maintenance dose	3 pens	0
		Maintenance: ☐ Inject 3 mg subcutaneously once daily	5 pens	
		☐ Other:		
		Pen Needles: ☐ 32G x 4mm ☐ 32G x 6mm ☐ Other:		

Injection Training
Injection training provided by ☐ Prescriber's Office ☐ Specialty Pharmacy ☐ Other: _____

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.

SHIPPING INFORMATION

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