Anti-Obesity Agents Form

Date: _____

Member's Name: _____

Member ID or Alliance Ref #: _____

Drug name, strength, quantity & refills: _____

_____

Patient's Height/Weight: _____Date Taken: _____

Patient's BMI: _____

List of Previous Failures in Weight Loss Programs: _____

_____

Please check all that apply for the patient:

- ☐ Hypertension
- ☐ Dyslipidemia
- ☐ Prediabetes
- ☐ Type 2 Diabetes
- ☐ Metabolic Syndrome
- ☐ NAFLD/NASH
- ☐ Sleep Apnea
- ☐ PCOS
- ☐ Osteoarthritis
- ☐ Stress Incontinence
- ☐ GERD
- ☐ Disability/Immobility
- ☐ Psychological Disorder/Stigmatization

✱ **Please fax this completed form to the Alliance Pharmacy department at (831) 430-5851**