ARGUS
Our Interest is You.

Weight Loss, Diabetes Medication Request Form

Health Insurance

The prescribing physician (General Practitioner or Specialist) is required to complete this coverage request form. Please use a separate form for each drug and submit the completed forms and corresponding consult note for review and approval to **overseascare@argus.bm**

Patient Information	Prescribing Provider Information
Patient Name	Prescriber Name
Certificate Number	Prescriber Phone
Date of Birth	Prescriber Fax
Patient Phone	Prescriber Address
Patient Email	Provider Office Email
Prescriber Tax I.D. (overseas provider)	Provider NPI (overseas provider)

Medication/Medical and Dispensing Information

Medication Name			
☐ Semaglutide Dosage:	☐ Tirzepatide Dosage:	☐ Liraglutide Dosage:	☐ Other: Dosage:
☐ New Prescription ☐ Refill		Starting BMI:	Current/Updated BMI:
Name of Weight Management Programme/Registered Dietician:			
Name of Pharmacy:			
Diagnosis		ICD 10 Diagnosis Codes	
Has the patient tried any other medications for this condition?			
☐ Yes (complete below) ☐ No			
Drug Name & Dosage	Duration of Therapy (specify dates)	Response/Reason for failure/Allergy	
Required Clinical Information – Please provide all relevant clinical information and reference attachments			

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Health Insurance

For completion by the Insurer	
☐ Approved	
Authorisation Number	**Case Number**
☐ Denied	
Reason for Denial	
Coverage	

Reviewer's Name *(please print)* | Reviewer's Signature | Date (MM/DD/YY)