Weight Management Clinic at Arete Family Care

Prior to your first appointment, you must complete the following forms. If these are not completed, you may be required to reschedule your appointment.

- Insurance questionnaire
- Personal history questionnaire
- PHQ-9
- ACE-Q

You will be required to have monthly visits to obtain prescription refills until a maintenance dose is achieved. It is best to schedule your follow-up appointment as you leave each visit to ensure you are scheduled before you run out of medication. For those using mail-order pharmacy, please take the shipping time into consideration.

Please be prepared to have labs drawn at your first appointment as outside labs may not be accepted.

If you and the provider together decide to submit medications through insurance, the prior authorization process can take three - five business days or more. You are welcome to send a portal message for a status update. *Please be kind and patient during this process*. Often, you may receive a generic denial from your insurance before our clinic receives a detailed denial of why the medication was denied. Depending on the reason for the denial, our staff can resubmit a prior authorization after we gather further information from you or review notes from other sources. **We do not complete appeals if the second prior authorization is denied. If this occurs, you may utilize manufacturer coupons or Lilly Direct*.

*An alternative to insurance reimbursement for GLP-1 medications, is a prescription for Zepbound to LillyDirect, a cash-pay mail order pharmacy. We are not using compound pharmacies.

During your first appointment*, we will complete a Resting Metabolic Rate (RMR) test. This provides more information about your metabolism and current calorie needs. For patients with a low RMR, medications may not be helpful; instead of solely decreasing their calorie intake, we need to also increase their metabolism so more calories are burned through the day. If this is the case, further education will be provided.
*For those with type 2 diabetes, this test will not be mandatory but is still an option.

The RMR test costs $250. We do not bill this test to insurance, but it is a valuable tool to assist in the weight management process. **Instructions for this test are attached on the following page.**

Resting Metabolic Rate (RMR) Reevue Patient Instructions

Prior to coming in for your appointment:

- Do not exercise for at least 4 hours if the activity is moderate, or 14 hours if it involves vigorous resistance training.
- Do not eat 4 hours prior (water is okay)
- Do not consume stimulants such as coffee, tea, sodas, cold medications for 4 hours prior
- No tobacco or alcohol for 2 hours prior

Testing will be rescheduled if these conditions are not met as the results may not be inaccurate.

During your appointment:

- This test costs $250 and is not billed through insurance. Payment is expected at checkout.
- You will sit quietly for 10 minutes prior to the test. The test itself will take approximately 10 minutes.
- You may sit or lie down - whichever is more comfortable.
- A nose clip will be placed on your nose, and you will be given a disposable mouthpiece to breathe through. The mouthpiece is connected to the ReeVue machine by a hose, which measures how much oxygen you exhale. Breathing must only occur through the mouthpiece to ensure accurate measurement. The mouthpiece and tubing are disposable items used only by you.
- Your results will be given to your provider for interpretation and guidance.

Frequently Asked Questions

What is Resting Metabolic Rate (RMR)?

Resting Metabolic Rate refers to the energy required to sustain vital body functions while at rest. It is a key determinant of your daily energy needs and plays a significant role in body weight regulation – essentially, how many calories you need to maintain your current weight.

What are the benefits of knowing my RMR?

It provides proof of normal metabolism before starting weight loss medications, which can lower your metabolic rate. If your metabolism is already low, it may decrease further with medication.

Understanding your daily caloric needs is essential for effective weight loss. Online predictive formulas are not individualized, and their estimation errors can be avoided through valid measurements using indirect calorimetry.

What do my test number mean?

RMR indicates how many calories you need daily to maintain your current weight. For weight loss, you should consume between 200-500 calories per day below your RMR, but never go below 1,000 calories per day.

Patient Name: Date of Birth

Weight Management Insurance Review

Some insurance plans do not cover medications for weight loss. Others require their members to have tried or have a contraindication to oral options. In addition, each plan generally has a preferred injectable medication. These decisions are plan specific and vary within the same insurance company.

Check with your insurance plan regarding the following questions prior to your appointment for weight management if you would like to pursue insurance coverage.

Date of call: **Insurance plan contacted:**

1) Does my plan cover weight loss medications for obesity?
2) Does my plan cover GLP-1 medications for obesity?
   Examples of GLP-1's: Zepbound, Ozempic, Wegovy, Mounjaro
   If yes, what are the preferred medications/brands:

    a. Are there criteria necessary to obtain coverage for this medication? (minimum BMI, diabetes, sleep apnea, other health conditions, failure or contraindication to other medications)
        i. If yes, please explain:

If no, which medications do my plan cover for weight loss/ obesity?

If possible, please submit the paperwork (all three pages) to Arete prior to your Initial Weight Management appointment with Sarah Tolliver, PA. This provides more time for her to discuss your care and plan during the appointment.

Forms can be submitted to email at info@afcak.com OR through the portal (preferred option) 24116.portal.athenahealth.com – *Log in – Messages – Start New Message – Medication Question* – Fill out the required steps then choose the attachment button before sending the message.

**This paperwork is available as a fillable PDF on our website – *www.afcak.com* – *Patient Resources – Forms*, and also on the portal through these steps: *My Health – Forms and Documents – Weight Management Packet*

Patient Name: Date of Birth

Personal History

1. Are you currently taking medication for weight loss?
    a. What was your initial weight prior to starting weight loss medication?
    b. When did you start your current medication?
    c. Who prescribed the initial prescriptions? (clinic name)
2. Have you completed any weight management programs in the past?
3. What are you currently doing for exercise?
4. Have you seen a nutritionist?
5. What weight loss medications have you tried in the past? *Please include when, the duration, and why you stopped*

Please place a checkmark if YES, if NO, please leave blank

- ❑ Do you have Type 2 diabetes?
- ❑ Do you take insulin or sulfonylureas? (glipizide, glimeperide, glyburide)
- ❑ Do you have a history of failure, intolerance, or contraindication to *metformin*?
    - Maximum daily dose of metformin: _____
- ❑ Do you have a history of failure to achieve acceptable glycemic control with V*ictoza*?
- ❑ Are you pregnant, plan to become pregnant, breastfeed, or plan to breastfeed?
- ❑ Do you have severe problems with your stomach, such as slow emptying of your stomach (gastroparesis) or problems digesting food?
- ❑ Are you unable to self-inject due to any of the following: lipohypertrophy, physically or visually impaired, or needle-phobia to the degree that you refuse any injectable therapy or medication procedure?
- ❑ Do you have a family history or personal history of medullary thyroid cancer?

Do you have any of the following problems:

- ❑ Sleep apnea
- ❑ Fatty liver
- ❑ Acid reflux
- ❑ Osteoarthritis
- ❑ Depression
- ❑ Anxiety or other mood disorder
- ❑ Heart Disease
- ❑ High cholesterol
- ❑ Hypertension (high blood pressure)
- ❑ Smoke tobacco
- ❑ History of heart attack or stroke
- ❑ History of gallstones
- ❑ History of pancreatitis
- ❑ History of abdominal surgery

Patient Name: Date of Birth

PHQ9 Over the **last two weeks,** how often have you been bothered by any of the following problems (*round up if in between)*	Not at all (0)	Several days (1)	More than half the days(2)	Nearly every day (3)
1. Little interest or pleasure in doing things	◯	◯	◯	◯
2. Feeling down, depressed, or hopeless	◯	◯	◯	◯
3. Trouble falling or staying asleep, or sleeping too much	◯	◯	◯	◯
4. Feeling tired or having little energy	◯	◯	◯	◯
5. Poor appetite or overeating	◯	◯	◯	◯
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	◯	◯	◯	◯
7. Trouble concentrating on things, such as reading the newspaper or watching television	◯	◯	◯	◯
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving about a lot more than usual	◯	◯	◯	◯
9. Thoughts that you would be better off dead, or of hurting yourself in some way	◯	◯	◯	◯
If you checked off any problems, how difficult have these made it for you to do work, take care of things at home, or get along with other people? (circle one) **Not difficult at all** ◯ **Somewhat difficult** ◯ **Very difficult** ◯ **Extremely difficult** ◯				
Total Score:_____				

Adverse Childhood Experience Questionnaire for Adults

Our relationships and experiences—even those in childhood—can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may be affecting your health today or may affect your health in the future.

*From the list below, please place a checkmark next to each ACE category that you **experienced prior to your 18th birthday***

- ❑ Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?
- ❑ Did you lose a parent through divorce, abandonment, death, or other reason?
- ❑ Did you live with anyone who was depressed, mentally ill, or attempted suicide?
- ❑ Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?
- ❑ Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?
- ❑ Did you live with anyone who went to jail or prison?
- ❑ Did a parent or adult in your home ever swear at you, insult you, or put you down?
- ❑ Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?
- ❑ Did you feel that no one in your family loved you or thought you were special?
- ❑ Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?

Total # of checked boxes: ____

Do you believe that these experiences have affected your health? ◯ Not Much ◯ Some ◯ A lot