ProCare Rx

Belviq® lorcaserin

Ticket #: ____________ Request Date: ____________ Request Time: ____________

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of **Belviq®** lorcaserin. Based on recent clinical information, we require more information before this prescription can be paid by the patient's pharmacy benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information			
Patient Name:	Plan Name/Plan ID:		
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:	

B. Physician Information			
Physician Name:	Physician Address:		
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:

C. Pharmacy Information			
Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:

D. Clinical Information (Please fill out the following information: circle all that apply)

1. Please provide documentation that the patient has been on a low-calorie diet, increased physical activity, and behavior therapy for a minimum of 6 months with monthly weight values.
2. Is this patient pregnant or intend to get pregnant over the intended course of treatment (validated by documentation of 2 negative pregnancy tests)? YES NO
3. Does the patient have an initial body mass index (BMI) of: 30 kg/m² or greater (obese), or 27 kg/m² or greater (overweight) in the presence of at least one weight-related co-morbid condition, (e.g., hypertension, dyslipidemia, type 2 diabetes)? YES NO
4. Please indicate patients BMI, Weight , (and weight related comorbid condition if applicable)

   BMI = ____________Kg/m²

   Weight = ___________Kg/lbs. (Please specify)

   Weight Related Co-Morbid Condition(s): ____________________________
5. <u>For Reauthorization only:</u> **(Week 12 and beyond)**

   Please document patient's current weight ___________Kg/lbs

   What percentage weight loss is this compared to start date? ____________%

Authorized Medical Signature:	
Telephone:	**Date:**

When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.

Prior authorization forms are reviewed at least annually and are available at www.procarerx.com. Medical Review Criteria are reviewed at least annually. Revised 09/2015