ProCare Rx

Egrifta® tesamorelin

Ticket #: _____ Request Date: _____ Request Time: _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of Egrifta® tesamorelin. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health 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:	QTY and Days Supply:	NDC # and GCN:

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

D. Clinical Information (Please fill out the following information: circle all that apply)	
Patient Diagnosis:	☐ ICD-9 Code ☐ ICD-10 Code

1. Does the patient have a diagnosis of HIV? YES NO
2. Does the patient have excess abdominal fat secondary to HIV associated with lipodystrophy? YES NO

Dosing Recommendations: 2mg subcutaneously once a day.

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.