ProCare Rx

Qsymia®
phentermine and topiramate
extended-release

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

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of Qsymia® phentermine and topiramate ER. 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) *For Re-Authorization, complete Q4 and Q5 only.*

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 the 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/m^2 or greater (obese), or 27 kg/m^2 or greater (overweight) in the presence of at least one weight-related comorbid condition, (e.g. hypertension, dyslipidemia, type 2 diabetes)? YES NO
4. Please indicate patient's BMI, Weight, Height (and weight-related comorbid conditions if applicable):

   BMI = _____Kg/m^2 Weight Related Co-Morbid Condition(s) _____

   Weight = _____Kg/lbs Height = _____inches/cm (Please provide documentation to support values.)

5. <u>For Reauthorization Only</u>:

   Please document dose and percentage of body weight loss that patient has had in each of the past 6 months.

   Note: This medication will not be approved if weight loss is less than 5% over 6 months.

   Date: _____/_____/_____ Weight: _____ Dose: _____

   Date: _____/_____/_____ Weight: _____ Percentage weight loss over 6 months: _____%

Authorized Medical Signature:	
Telephone:	Date:

<u>When Completed Return To</u>:

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.