

US Family Health Plan

Prior Authorization Request Form for lorcaserin (Belviq, Belviq XR)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed to 617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Initial approval is 4 months, renewal is 12 months

Step 1 Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID #: _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. Is this request for continuation of therapy?	<input type="checkbox"/> Yes Proceed to question 12	<input type="checkbox"/> No Proceed to question 2
2. Is the patient GREATER THAN or EQUAL to 18 years of age?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Has the patient tried and failed to achieve a 5 percent reduction in baseline weight after a 12 week course of phentermine, benzphetamine, diethylpropion, or phendimetrazine?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No Proceed to question 4
4. Does the patient have a history of cardiovascular disease (e.g. arrhythmias, coronary artery disease, heart failure, stroke, uncontrolled hypertension), hyperthyroidism, or significant contraindication to phentermine, benzphetamine, diethylpropion, or phendimetrazine?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Does the patient have BMI GREATER THAN or EQUAL to 30, or a BMI GREATER THAN or EQUAL to 27 for those with risk factors in addition to obesity (diabetes, impaired glucose tolerance, dyslipidemia, hypertension, sleep apnea)?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved
6. Has the patient has engaged in a trial of behavioral modification and dietary restriction for at least 6 months and has failed to achieve the desired weight loss, and will remain engaged throughout course of therapy?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved

Prior Authorization Request Form for
lorcaserin (Belviq, Belviq XR)

7. Is the patient an Active Duty Service Member?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No Proceed to question 9
8. Is the individual enrolled in a Service-specific Health/Wellness Program AND adhere to Service policy, AND will remain engaged throughout course of therapy?	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No STOP Coverage not approved
9. Is the patient pregnant?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 10
10. Does the patient have impaired glucose tolerance or diabetes?	<input type="checkbox"/> Yes Proceed to question 11	<input type="checkbox"/> No Sign and date below
11. Has the patient tried metformin first, or is concurrently taking metformin?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
12. Is the patient currently engaged in behavioral modification and on a reduced calorie diet?	<input type="checkbox"/> Yes Proceed to question 13	<input type="checkbox"/> No STOP Coverage not approved
13. Has the patient lost GREATER THAN or EQUAL to 5 percent of baseline body weight since starting medication?	<input type="checkbox"/> Yes Proceed to question 14	<input type="checkbox"/> No STOP Coverage not approved
14. Is the patient pregnant?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 15
15. Is the patient an Active Duty Service Member?	<input type="checkbox"/> Yes Proceed to question 16	<input type="checkbox"/> No Sign and date below
16. Does the individual continue to be enrolled in a Service-specific Health/Wellness Program AND adheres to Service policy, AND will remain engaged throughout course of therapy?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

3

Prescriber Signature

Date

[22 August 2018]