XENICAL
Drug Evaluation Review Form

Fax to: WellCare Pharmacy (866) 825-2884

Authorization Period
- ❑ Initial 3 Months
- ❑ 1st Renewal 3 Months
- ❑ 6 Months Maintenance

Select Health Plan:
- ❑ **HealthEase**
- ❑ **Staywell**

PLEASE PRINT CLEARLY

						DATE					
Member ID#						Provider ID#					
Name						Name					
Address						Address					
City		State		ZIP		City		State		ZIP	
Phone		DOB				Phone		Fax			
Date Recorded		Ht		Wt		Contact					
Dx		ICD9				Specialty					

Select Therapy: ❑ Initial ❑ Continuation of Existing ❑ Restart After 90 Days

Please complete the following:	Yes	No
1. Patient currently has a (BMI) >27kg/m2 with at least one other cardiovascular risk factor. (Only necessary for initial request)		
2. Does the patient have *any* of the following co-morbid conditions that are contraindications to receive Orlistat? • Chronic Malabsorbtion Syndrome • Calcium Oxalate Nephrolithiasis • Organic cause of Obesity (hyperthyroidism) • Cholestasis Hyperoxaluria • Pregnant or lactating • Surgery for weight reduction		
3. Is the patient on any of the following medication for weight reduction, including phentermine, sibutramine, or weight reducing stimulants?		
4. Only approval dosage is 120mg po TID		
5. Attach a copy of pertinent laboratory reports. Lab values must have been drawn and measured within 30 days of this request. The provider must retain copies of all documentation for five years.		

PHYSICIAN SIGNATURE _____

For Internal Use Only

Date	Spoke To	Left Message For	Comments	Initials

Additional Comments

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