



Please note: All information below is required to process this request.  
 Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern



**Belvii<sup>®</sup> & Belvii<sup>®</sup> XR Prior Authorization Request Form**  
 DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information <small>(required)</small>	Provider Information <small>(required)</small>
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Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information <small>(required)</small>
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Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>	Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>		

Clinical Information <small>(required)</small>
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**Select the requested drug below:**  
 Belvii       Belvii XR

**What is the patient's diagnosis for the medication being requested?** \_\_\_\_\_  
 ICD-10 Code(s): \_\_\_\_\_

**Clinical information:**  
 Does the patient have a body mass index (BMI) of 40 or greater?  Yes  No  
*Chart notes/lab documentation must be provided*  
 Does the patient have a BMI of 35 with co-morbid conditions that includes coronary artery disease, hypertension, congestive heart failure, diabetes, dyslipidemia, or sleep apnea?  Yes  No  
 If **Yes** to the above, document the co-morbid condition(s): \_\_\_\_\_  
*Chart notes/lab documentation must be provided*

**Current height and weight:**  
 Member's current Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Reauthorization:**  
**If this is a reauthorization request, answer the following:**  
 Has the patient achieved 5% weight loss by week 12?  Yes  No  
*Chart notes/lab documentation must be provided*  
 Member's current Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**\*\*Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.\*\***  
**\*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.\***

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

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Please note: This request may be denied unless all required information is received.  
 For urgent or expedited requests please call 1-800-711-4555.  
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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