

Belviq® & Belviq® XR Prior Authorization Request Form
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| Member Information (required) | | | Provider Information (required) | | |
|---|--------|------|--|--------|--------------|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NP#: | | Specialty: |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |
| Medication Information (required) | | | | | |
| Medication Name: | | | Strength: | | Dosage Form: |
| <input type="checkbox"/> Check if requesting brand | | | Directions for Use: | | |
| <input type="checkbox"/> Check if request is for continuation of therapy | | | | | |
| Clinical Information (required) | | | | | |
| 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Chart notes/lab documentation must be provided</i> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes to the above, document the co-morbid condition(s): _____ <i>Chart notes/lab documentation must be provided</i> | | | | | |
| 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Chart notes/lab documentation must be provided</i> 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?

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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