Wegovy (semaglutide) Prior Authorization Form

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

West Virginia Medicaid
Bureau for Medical Services

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Fax: 1-800-531-7787
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Patient Name (Last) | (First) | (M) | WV Medicaid 11 Digit ID# | Date of Birth (MM/DD/YYYY)

Prescriber Name (Last) | (First) | (Credentials)

Prescriber Address (Street) | (City) | (State) | (Zip)

Prescriber 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

Pharmacy Name (if applicable)

Pharmacy Address (Street) | (City) | (State) | (Zip)

Pharmacy 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

Important Notes: Preauthorization for medical necessity does not guarantee payment.
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Drug Name | Strength | Route of Administration

Directions | Diagnosis | ICD Diagnosis Code (if available)

If the prescriber is a mid-level practitioner (i.e. nurse practitioner, physician assistant, etc), does the prescriber have a clinical specialty certification/degree in cardiology, vascular surgery, or neurology? ☐ Yes ☐ No

If yes, please indicate the clinical specialty certificate/degree and the accrediting body.

If no, a consult with a physician is required for approval. Name: NPI:

Will the patient utilize Wegovy in combination with any other agent in the glucagon-like peptide-1 (GLP-1) or glucose-dependent insulinotropic (GIP)/GLP-1 class? ☐ Yes ☐ No

If yes, please indicate the GLP-1 or GIP/GLP-1 agonist that will be prescribed concurrently.

Please document the patient's most recent hemoglobin A1C lab result (from within the last six months) and **attach the lab report.** A1C: Date:

Is Wegovy being prescribed in combination with lifestyle modification measures (including a reduced calorie diet and increased physical activity)? ☐ Yes ☐ No

Other Pertinent Information.

Please choose and complete **only one** of the following two diagnosis areas:

Diagnosis: Reduction of Major Adverse Cardiovascular Events

Please provide the patient's current (from within the last 90 days) height, weight, and BMI, and **attach the chart note from the visit the measurements were taken.**

Height (inches): | Weight (pounds): | BMI (kg/m^2): | Date Measured:

Does the patient have a history of a myocardial infarction? ☐ Yes ☐ No

If yes, please document the date the myocardial infarction occurred.

Does the patient have a history of a stroke? ☐ Yes ☐ No

If yes, please document the date the stroke occurred.

Does the patient have symptomatic peripheral arterial disease? ☐ Yes ☐ No

If yes, please respond to the following questions regarding the patient's peripheral arterial disease:

What is the patient's most recent ankle-brachial systolic pressure index (ABI) at rest? ABI: | Date Measured:

Has the patient undergone a peripheral vascular procedure? ☐ Yes ☐ No

Has the patient undergone an amputation due to atherosclerotic disease? ☐ Yes ☐ No

Does the patient have a diagnosis of diabetes mellitus? ☐ Yes ☐ No

Diagnosis: Metabolic Dysfunction Associated Steatohepatitis (MASH)

Initial Authorization:

Please indicate which diagnostic testing confirmed the diagnosis of MASH, and **attach the imaging/pathology/laboratory report of the diagnostic test.**

☐ Liver biopsy ☐ Vibration-controlled transient elastography (VCTE) ☐ Magnetic Resonance Elastography (MRE)

☐ Other (please describe)

Please indicate the patient's fibrosis score. ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4

Does the patient have a diagnosis of diabetes mellitus? ☐ Yes ☐ No

If yes, please indicate which medication(s) the patient is currently prescribed to treat diabetes mellitus along with the strength and directions.

If the patient has a diagnosis of type 2 diabetes mellitus, please detail all previous GLP-1 and GIP/GLP-1 agonist medications the patient has previously attempted. For each previously attempted trial, please include the medication name, dose/directions attempted (including all titrations), date range, and outcome.

Does the patient have a diagnosis of hypertension? ☐ Yes ☐ No

If yes, please indicate which medication(s) the patient is currently prescribed to treat hypertension along with the strength and directions.

Does the patient have a diagnosis of hyperlipidemia? ☐ Yes ☐ No

If yes, please indicate which medication(s) the patient is currently prescribed to treat hyperlipidemia along with the strength and directions.

Re-Authorization:

Has the patient progressed to cirrhosis? ☐ Yes ☐ No

Has the patient exhibited a positive response to therapy on semaglutide? ☐ Yes ☐ No

If yes, please indicate how the patient's response was assessed and **attach the imaging/pathology/laboratory report of the diagnostic test** (check all that apply).

☐ VCTE Date of VCTE: | Liver Stiffness Measurement (LSM): | Controlled Attenuation Parameter (CAP):

☐ MRE Date of MRE: | Liver Stiffness Measurement (LSM): | Controlled Attenuation Parameter (CAP):

☐ Liver function test (LFT) Pretreatment LFT Date: | Pretreatment ALT: | Current LFT Date: | Current ALT:

☐ Biopsy Date of Biopsy: | Fibrosis Score (F0-F4): | Steatosis Score (S0-S3):

Attestation: Your signature (manually or electronically) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.

☐ Check here for electronic signature

Prescriber or Pharmacist Signature | Date: (MM/DD/YYYY)