

Wegovy® (semaglutide) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information

Pharmacy Billing (NDC: _____) Start Date (or date of next dose): _____

Dose: _____ Regimen: _____

Pharmacy Information

Pharmacy NPI: _____ Pharmacy Name: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria**For Initial Authorization: (Page 1 of 2)**

1. Does the member have type 1 diabetes mellitus (T1DM) or type 2 diabetes mellitus (T2DM)? Yes ___ No ___
2. Will member use Wegovy® in combination with other semaglutide-containing products or any other glucagon-like peptide-1 (GLP-1) receptor agonist? Yes ___ No ___
3. Will Wegovy® be used in conjunction with diet and exercise? Yes ___ No ___ [clinical documentation (i.e. office notes) of this discussion with the member must be included with the request]
4. **Please indicate the diagnosis and information:**
 - To reduce the risk of major adverse cardiovascular (CV) events**
 - a. Does the member have established cardiovascular disease (CVD)? Yes ___ No ___
 - b. Is the member obese or overweight? Yes ___ No ___
 - c. Does the member have a history of any of the following? (Check all that apply and clinical documentation must be submitted with the request)
 - Previous myocardial infarction
 - Previous stroke
 - Symptomatic peripheral arterial disease confirmed by 1 of the following:
 - Intermittent claudication with ankle-brachial index <0.85 at rest
 - Peripheral arterial revascularization procedure
 - Amputation due to atherosclerotic disease
 - d. Member's body mass index (BMI): _____ Date Taken: _____
 - e. Member's hemoglobin A1C (HbA1c): _____ Date Taken: _____
 - f. Is the member currently receiving guideline-directed management and therapy (GDMT) for CVD (e.g., antihypertensives, lipid-lowering agents, antiplatelets), as documented in the member's pharmacy claims history, unless contraindicated? Yes ___ No ___
 - i. Please provide the member's current GDMT for CVD: _____
 - ii. If contraindicated, please provide details: _____

(Page 1 of 2)PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization UnitFax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4CONFIDENTIALITY NOTICE

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Criteria

For Initial Authorization: (Page 2 of 2)

4. Please indicate the diagnosis and information: (continued)

Metabolic Dysfunction-Associated Steatohepatitis (MASH)

- a. Is diagnosis noncirrhotic MASH? Yes ___ No ___
- b. Does member have moderate-to-advanced liver fibrosis (e.g., stage F2 or F3) confirmed by at least 1 of the following? Yes ___ No ___ **(results of selected test must be submitted with the request)**
 - FibroScan with vibration controlled transient elastography (VCTE) ≥8kPa and controlled attenuation parameter (CAP) ≥280dB/min
 - Enhanced Liver Fibrosis (ELF) biochemical test score ≥9
 - Liver biopsy showing stage F2 or F3 fibrosis with NASH
- c. Does member have chronic liver disease other than metabolic dysfunction-associated steatotic liver disease (MASLD)? Yes ___ No ___
- d. Are metabolic comorbidities such as treatment for type 2 diabetes, dyslipidemia and hypertension being appropriately managed if applicable? Yes ___ No ___ N/A ___
- e. Is Wegovy® prescribed by, or in consultation with, a gastroenterologist or hepatologist (or an advanced care practitioner with a supervising physician who is a gastroenterologist or hepatologist)? Yes ___ No ___
 - i. If yes, please include name of the gastroenterologist or hepatologist recommending treatment with Wegovy: _____

Other: _____

5. Request is for:

- Titration dosing
- Maintenance dosing

6. Initial approvals will be for the titration period to allow initial and escalation dosing. A separate request must be submitted for each dose. Approvals will be for 8 weeks at a time to allow for proper dose escalation. An additional 8 weeks for each dose may be approved for those who experience intolerable adverse effects during dose escalation with proper documentation.

For Authorization of Maintenance Dosing: (approvals will be for 1 year)

- 1. Date of last dose: _____
- 2. Is the member tolerating maintenance dosing? Yes ___ No ___
- 3. Has the member developed T1DM or T2DM? Yes ___ No ___
- 4. Is the member continuing all of the following?
 - Reduced calorie diet
 - Increased physical activity
 - GDMT for CVD where applicable

(Page 2 of 2)

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

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