Wegovy Prior Authorization Form

Fax completed form to MedStar Family Choice-MD

1-888-243-1790 or 410-933-2274

ALL requests must be accompanied by MEDICAL RECORDS to support the request. MedStar Family Choice-Maryland MUST RENDER A DECISION WITHIN 24 HOURS. If MEDICAL RECORDS are INCOMPLETE, the request is subject to DENIAL. Return by fax to MedStar Family Choice-Maryland at: 410-933-2274

Patient Name: ________________________________ Date of Birth: _________________________

Patient MedStar Family Choice ID#: _______________ Medicaid ID#________________________

PLEASE NOTE:

- **WEGOVY MAY BE APPROVED ONLY TO REDUCE THE RISK OF MAJOR ADVERSE CARDIOVASCULAR EVENTS (MACE), IN COMBINATION WITH A REDUCED CALORIE DIET AND INCREASED PHYSICAL ACTIVITY, FOR ADULTS WITH ESTABLISHED CARDIOVASCULAR DISEASE AND WHO ARE EITHER OBESE OR OVERWEIGHT.**
- **WEGOVY WILL BE APPROVED FOR MAXIMUM OF 6 MONTHS PER REQUEST**

☐ Initial Therapy.

NOTE: monthly dose escalation required to reach maintenance by time of PA renewal

☐ Continuation of Therapy.

NOTE: Patient dose must be 1.7 mg or 2.4 mg for maintenance dosing

PATIENT HISTORY

☐ Documentation in the record that the patient does **NOT** have Type 1 DM or Type 2 DM.

☐ Documentation in the record that the patient has established atherosclerotic cardiovascular disease (ASCVD) **AND** is either obese or overweight.

☐ BMI within the **last 90 days**. BMI______ Height ______ Weight ______

☐ ASCVD documentation (check all that apply)

- ☐ Prior MI
- ☐ Prior stroke (ischemic or hemorrhagic)
- ☐ Intermittent claudication with ankle-brachial index (ABI) < 0.85
- ☐ Peripheral arterial revascularization procedure
- ☐ Amputation due to atherosclerotic disease.

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☐ Documentation that this patient is **NOT** currently using any other GLP1 or GLP1/GIP combination drug (e.g., Mounjaro, Ozempic, Rybelsus, Soliqua, Trulicity, Victoza, Xultrophy, or Zepbound).

☐ Documentation that this patient is **NOT** currently using a DPP4i (alogliptin, Januvia [sitagliptin], Onglyza [saxagliptin], Tradjenta [linagliptin]).

☐ Documentation that this patient does **NOT** have the following:

- a history of confirmed pancreatitis
- suicidal thoughts or new onset depression
- current pregnancy

By signing below, I, the prescriber of Wegovy attest that:

☐ **Wegovy is being prescribed in accordance with prescribing information, including screening for any black box warnings and all contraindications.**

☐ **I have INCLUDED ALL PERTINENT MEDICAL RECORDS related to this Wegovy request.**

Prescriber Signature: ________________________________ Date: ______________________

Prescriber Name/Office:_____________________________NPI #:_______________________

Prescriber Address: ____

Prescriber Phone Number: _________________ Prescriber Fax Number: ________________

Office Contact Name: ______________________ Office Contact Phone: _________________

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