maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Wegovy

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1 Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?
[] Initial (If checked, go to 2)

[] Continuation (If checked, go to 2)

2 What is the diagnosis or indication?
[] Reduction of Major Adverse Cardiovascular Events (If checked, go to 3)

[] Other (If checked, no further questions)

3 Does the patient have type I or type II diabetes mellitus? Yes No
[If yes, no further questions.]

If you have any questions, call: 1-888-258-8250

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4	Is the patient's age greater than or equal to 18 years? [If no, no further questions.]	Yes	No
5	Does the patient have a documented BMI within the last 90 days of greater than or equal to 27 kg/m2? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
6	Does the patient have established cardiovascular disease as evidenced by at least one of the following: A) Prior Myocardial Infarction, B) Prior Stroke (Ischemic or Hemorrhagic), C) Symptomatic Peripheral Arterial Disease (PAD) as demonstrated by intermittent claudication with ankle-brachial index (ABI) less than 0.85 (at rest), or peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
7	Does the provider attest that Wegovy will be prescribed in accordance with the manufacturer's recommended dosing? [If no, no further questions.]	Yes	No
8	Does the provider attest that the patient has been screened for all black box warnings and all contraindications? Note: Patient assessed for personal or family history of medullary thyroid carcinoma (MTC) or multiple endocrine neoplasia syndrome type 2 (MEN 2)	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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