



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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is this a request for INITIAL or CONTINUATION of therapy with the requested medication? <input type="checkbox"/> Initial (If checked, go to 2) <input type="checkbox"/> Continuation (If checked, go to 2)
2	What is the diagnosis or indication? <input type="checkbox"/> Reduction of Major Adverse Cardiovascular Events (If checked, go to 3)

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

Version 02.2026

PRIOR AUTHORIZATION REQUEST

Noncirrhotic Metabolic Dysfunction-Associated Steatohepatitis (MASH) (If checked, go to 9)

Other (If checked, no further questions)

- | | | | |
|----|--|-----|----|
| 3 | Does the patient have type I or type II diabetes mellitus?
[If yes, no further questions.] | Yes | No |
| 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/m ² ? 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).]
[No further questions.] | Yes | No |
| 9 | Is the patient's age greater than or equal to 18 years?
[If no, no further questions.] | Yes | No |
| 10 | Does the patient have type I or type II diabetes mellitus?
[If yes, no further questions.] | Yes | No |
| 11 | Does the patient have a diagnosis of MASH confirmed with liver fibrosis testing obtained within 180 days of this request?
[Note: Diagnosis of noncirrhotic MASH with liver fibrosis stage F2 or F3, confirmed by liver biopsy or a non-invasive test (Elastography, pSWE, MRE, ELF, Fibrotest, FNI, MACK-3).]
ACTION REQUIRED: Submit supporting documentation.
[If no, no further questions.] | Yes | No |

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12	Does the provider attest that the patient has not been diagnosed with other causes of chronic liver disease other than non-alcoholic fatty liver disease (NAFLD)? [If no, no further questions.]	Yes	No
13	Does the provider attest that the patient does not have liver cirrhosis or a history of decompensated liver disease? [If no, no further questions.]	Yes	No
14	Does the provider attest that the patient does not have a history of liver transplantation or current/prior hepatocellular carcinoma? [If no, no further questions.]	Yes	No
15	Does the provider attest that the patient does not consume excessive alcohol? [Note: 20 grams per day for female and 30 grams per day for males.] [If no, no further questions.]	Yes	No
16	Does the provider attest that the patient will not be treated concurrently with other medication(s) indicated for noncirrhotic MASH? [If no, no further questions.]	Yes	No
17	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).] [If no, no further questions.]	Yes	No
18	Is the medication being prescribed by or in consultation with a gastroenterologist or hepatologist? [If no, no further questions.]	Yes	No
19	Does the provider attest that Wegovy will be prescribed in accordance with the manufacturer's recommended dosing?	Yes	No

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

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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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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