OKLAHOMA Health Care Authority

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State of Oklahoma SoonerCare

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. Please indicate the diagnosis and information:
   - ☐ To reduce the risk of major adverse cardiovascular (CV) events
   - ☐ Other
2. Does the member have established cardiovascular disease (CVD)? Yes☐ No☐
3. Is the member obese or overweight? Yes☐ No☐
4. 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
5. Member's body mass index (BMI): Member's hemoglobin A1C (HbA1c):
6. Does the member have type 1 diabetes mellitus (T1DM) or type 2 diabetes mellitus (T2DM)? Yes☐ No☐
7. Will member use Wegovy® in combination with other semaglutide-containing products or any other glucagon-like peptide-1 (GLP-1) receptor agonist? Yes☐ No☐
8. 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☐
   a. Please provide the member's current GDMT for CVD:
   b. If contraindicated, please provide details:

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.	

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

9. Will Wegovy® be used in conjunction with diet and exercise? Yes___ No___ (clinical documentation of member's diet and exercise program must be included with the request)
10. Request is for:
    - ☐ Titration dosing
    - ☐ Maintenance dosing
11. 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 4 weeks at a time to allow for proper dose escalation. An additional 4 weeks for each dose may be approved for those who experience intolerable adverse effects during dose escalation with proper documentation.

Additional information:

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

Additional Information:

(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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