SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Wegovy® (semaglutide) - GLP-1 Receptor Agonists for Cardiovascular Risk Reduction

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

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Initial Request Requirements: 6 months

- ❑ The member is 45 years of age or older; **AND**
- ❑ The medication is prescribed by a cardiologist or vascular specialist; **AND**
- ❑ The member has a clinical history of one of the following;
  - ❑ Myocardial infarction (MI), defined as cardiac biomarkers, an electrocardiogram, or cardiac imaging; **OR**
  - ❑ Stroke, defined as neurological dysfunction as a result of a hemorrhage or infarction; **OR**
  - ❑ Peripheral artery disease, as defined by intermittent claudication with ankle-brachial index less than 0.85 at rest, or peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease;**AND**
- ❑ The member has not had a MI, stroke, transient ischemic attack, or hospitalization for unstable angina in the last 60 days; **AND**
- ❑ The member has a BMI ≥ 27 kg/m2; **AND**
- ❑ The provider attests that the member received individualized healthy lifestyle counseling; **AND**
- ❑ The member does not have a previous diagnosis of diabetes; **AND**
- ❑ The member does not have pancreatitis, acute suicidal behavior/ideation, personal or family history of medullary thyroid cancer or multiple endocrine neoplasia 2 syndrome

Renewal requests: 12 months

- ❑ The member continues to meet the criteria
- ❑ The member is being treated with a maintenance dosage of the requested drug

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

***Approved by the Pharmacy and Therapeutic Committee:** 8/21/2024
REVISED/UPDATED/REFORMATTED: ~~9/10/2024,~~ **10/02/2024**