

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

Drug Requested: (Select drug below)

<input type="checkbox"/> Wegovy [®] PEN (semaglutide)	<input type="checkbox"/> Wegovy [®] Tablets (semaglutide) <u>(requires additional documentation why injection cannot be utilized)</u>
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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.

(Continued on next page)

Initial Request: 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 Request: 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.****