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.**

Drug Requested: Wegovy® (semaglutide)- GLP-1 Receptor Agonists for Metabolic Dysfunction-Associated Steatohepatitis (MASH)

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.

- **FDA indicated medications only**
- **Must be prescribed by or in consultation with a hepatologist or gastroenterologist or other provider specializing in liver disease for the member to receive authorization.**

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Initial Request Requirements: 6 months

- ❑ The member is 18 years of age or older; **AND**
- ❑ The medication is prescribed by or in consultation with a hepatologist, gastroenterologist or other provider specializing in liver disease; **AND**
- ❑ The member has a diagnosis of MASH with results of baseline liver biopsy or noninvasive tests demonstrating the presence of stage F2 or F3 fibrosis by at least **ONE** of the following:
  - ❑ Liver biopsy; **OR**
  - ❑ Noninvasive tests (such as transient elastography, Fibroscan, or magnetic resonance elastography) performed within the last 6 months; **AND**
- ❑ The member has a BMI ≥ 18.5 kg/m2; **AND**
- ❑ The provider attests that the member received individualized healthy lifestyle counseling; **AND**
- ❑ The member does not have an A1C of >9.5% **AND**
- ❑ The member does not have known or suspected excessive consumption of alcohol according to the CDC's guidance; **AND**
- ❑ The member does not have hepatic decompensation or a MELD score of > 12 at screening; **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; **AND**
- ❑ The member is not concurrently on another GLP-1 receptor agonist

Renewal requests: 12 months

- ❑ The member has experienced clinical improvement on the requested medication
- ❑ 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.****

REVISED/UPDATED/REFORMATTED: ~~9/10/2025,~~ **11/19/2025**