SENTARA HEALTH PLANS

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) **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:** _____

Recommended Dosage:

- The recommended maintenance dosage of Wegovy® for the treatment of noncirrhotic MASH with moderate to advanced liver fibrosis is 2.4 mg injected subcutaneously once weekly.
- If patients do not tolerate the maintenance dosage of 2.4 mg once weekly, the dosage can be decreased to 1.7 mg once weekly. Consider reescalation to 2.4 mg once weekly

Quantity Limit: 4 syringes per 28 days

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.

Initial Authorization: 12 months

- ❑ Member is 18 years of age or older

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- ❑ Medication is prescribed by or in consultation with a hepatologist or gastroenterologist
- ❑ Member has a diagnosis of nonalcoholic steatohepatitis or metabolic dysfunction–associated steatohepatitis (NASH/MASH)
- ❑ Provider must submit **ONE** of the following
  - ❑ Biopsy results (completed within the last 6 months) documenting **BOTH** of the following:
    - ❑ Liver fibrosis stage F2 or F3
    - ❑ Non-alcoholic fatty liver disease activity score (NAS) of ≥ 4 with a score of > 1 in all the following: steatosis, ballooning, and lobular inflammation
  - ❑ Liver fibrosis stage F2 or F3 as determined by an elastography test (completed within the last 6 months), such as vibration-controlled transient elastography (i.e., FibroScan), magnetic resonance elastography (MRE), shear wave elastography; etc. **(must submit current test results)**
- ❑ In cases of indeterminate fibrosis stage (i.e., inconsistency between fibrosis stage and clinical presentation), a liver biopsy will be required to be submitted
- ❑ Member has three or more of the following metabolic risk factors that are managed according to standard of care **(verified by medical chart notes, lab test results and/or pharmacy claims)**:
  - ❑ Central obesity
  - ❑ Hypertriglyceridemia
  - ❑ Reduced high-density lipoprotein cholesterol
  - ❑ Hypertension
  - ❑ Elevated fasting plasma glucose indicative of diabetes or pre-diabetes
- ❑ Member has adopted liver-protective lifestyle interventions such as optimizing weight loss, dietary changes, and exercise and is compliant with treatment for comorbidities (i.e. hyperlipidemia, hypertension, diabetes; etc.)
- ❑ Current liver function (CMP) and CBC test results must be submitted
- ❑ Other causes of liver disease or hepatic steatosis have been ruled out (i.e., alcoholic steatohepatitis, acute fatty liver, autoimmune hepatitis, Hepatitis A, B or C, hemochromatosis, drug-induced liver disease)
- ❑ Member does **NOT** have significant alcohol consumption (alcohol consumption of more than 20 g per day for women and more than 30 g per day for men)
- ❑ Member does **NOT** have evidence of cirrhosis, hepatic decompensation, or hepatocellular carcinoma **(must submit documentation)**
- ❑ Member will **NOT** use concurrent therapy with another GLP-1 receptor agonist prescribed for another indication (i.e., Zepbound®, Saxenda®, Mounjaro®, Ozempic®, Trulicity®, Rybelsus®)
- ❑ **For combination therapy with Wegovy® and Rezdiffra®:** Documentation of insufficient clinical response to Rezdiffra® (i.e. lack of MASH/NASH resolution, no improvement in fibrosis score; etc.) after 6-month trial must be submitted

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Reauthorization: 6 months. 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.

- ❑ Member continues to meet **ALL** initial authorization criteria
- ❑ Member has experienced **ONE** of the following as determined by an elastography test, such as vibration-controlled transient elastography (e.g., FibroScan), magnetic resonance elastography (MRE), shear wave elastography or biopsy:
  - ❑ MASH/NASH resolution **AND** no worsening of fibrosis
  - ❑ No worsening of MASH/NASH **AND** improvement in fibrosis by ≥ 1 stage

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****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 Pharmacy and Therapeutics Committee**: 9/25/2025
REVISED/UPDATED/REFORMATTED: 10/22/2025