Wegovy and Zepbound
Prior Authorization Form
Incomplete forms will not be reviewed

Maryland Medicaid
Office of Pharmacy Services
Fax: (866) 440-9345
Phone: (833) 325-0105

Date (MM/DD/YYYY): _____

Patient Information

Name: _____ DOB (MM/DD/YYYY): _____ ❑ M ❑ F

Medicaid Assistance Number: _____

Height: _____ Weight: _____ BMI: _____ Date (MM/DD/YYYY): _____

Prescriber Information

Name: _____ NPI: _____

Contact Person: _____ Phone: _____ Fax: _____

Prescription Information

❑ Wegovy (semaglutide) ❑ Zepbound (tirzepatide)

Strength: _____ Quantity: _____ Refills: _____

Directions: _____

❑ Initial PA Request ❑ Renewal PA Request

Clinical Information (clinical documentation supporting the following must be submitted)

-Yes-	-No-	**Wegovy**
❑	❑	**Patient has established cardiovascular disease**. Date of cardiovascular event (MM/DD/YYYY): _____ ❑ Prior myocardial infarction ❑ Prior stroke ❑ Symptomatic peripheral arterial disease evidenced by ❑ Intermittent claudication with ankle-brachial index (ABI) less than 0.85 (at rest) ❑ Peripheral arterial revascularization procedure ❑ Amputation due to atherosclerotic disease ❑ Yes ❑ No Patient has BMI of 27kg/m^2 or greater within the last 90 days ❑ Yes ❑ No Prescribed by or in consultation with a cardiologist ❑ Patient not concurrently using any other GLP-1 receptor agonists.
❑	❑	**Patient has non-cirrhotic metabolic dysfunction-associated steatohepatitis (MASH)** ❑ Yes ❑ No Patient has moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) ❑ Yes ❑ No Prescribed by or in consultation with a gastroenterologist or hepatologist ❑ Patient not concurrently using any other GLP-1 receptor agonists. ❑ Patient not concurrently using other medication(s) indicated for noncirrhotic MASH

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-Yes-	-No-	**Zepbound**
❑	❑	Patient has moderate to severe obstructive sleep apnea (OSA) diagnosed by polysomnography or home sleep study with an apnea-hypopnea index (AHI) ≥ 15 events per hour with obesity: Date of Polysomnography (MM/DD/YYYY): _____ AHI Score: _____
❑	❑	Prescribed by or in consultation with a sleep specialist, pulmonologist, or other experienced provider in treating OSA
❑	❑	Patient has BMI of 30 kg/m^2 or greater within the last 90 days
❑ If therapy is requested for beyond 12 months from initial PA, attach repeat documentation confirming moderate to severe OSA annually ❑ Patient not concurrently using any other GLP-1 receptor agonists.		

I attest that

❑ Patient has engaged in a trial of weight loss management in the past 6 months and failed to achieve weight loss.

❑ All FDA Prescribing information, Precautions/warnings, Contraindications to treatment, and any Black Box Warnings have been considered.

❑ The medication will be used in conjunction with a reduced calorie diet and exercise plan.

❑ I certify that the benefits of the treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge. Supporting medical documentation is kept on file in the patient's medical record to support a positive clinical response.

❑ I certify that the patient is not enrolled in any study involving the requested drug.

MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.

Prescriber signature: _____ Date (MM/DD/YYYY): _____