Wegovy Prior Authorization Form
Maryland Medicaid Pharmacy Program
Fax#: (866)440-9345 | Phone #: (800)932-3918

Incomplete forms will not be reviewed

Date:(MM/DD/YYYY)_____

Patient information

Name: _____ DOB:(MM/DD/YYYY)_____

Participant's Maryland Medicaid Number: _____ Sex: ☐ Male ☐ Female ☐ Other

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Prescriber Information

Name: _____ NPI#: _____

Phone: _____ Fax #: _____

Contact Person for this Request

Name: _____ Phone#: _____

Email: _____ Fax #: _____

Requested Drug Information

◯ New Request ◯ Renewal Request

Strength: _____ Quantity: _____

Directions: _____

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

Request Requirements:

☐ Patient has BMI of 27kg/m^2 or greater within the last 90 days
Current BMI _____ Weight _____ Height _____ Date_____ (MM/DD/YYYY)

☐ Patient has established cardiovascular disease Date of cardiovascular event _____

- ☐ Prior myocardial infraction
- ☐ Prior stroke
- ☐ Peripheral arterial disease
  - ☐ Intermittent claudication with ankle-brachial index (ABI) less than 0.85 (at rest), or
  - ☐ Peripheral arterial revascularization procedure, or
  - ☐ Amputation due to atherosclerotic disease

☐ Patient does not have type 1 or 2 diabetes.

☐ Patient not concurrently using with other semaglutide-containing products or GLP-1 receptor agonists.

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

☐ I attest that all FDA precautions/warnings, contraindications to treatment, and any Black Box Warnings have been considered.

☐ I attest that 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 to Wegovy.

☐ 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

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