Wegovy or 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: Name: _____ Phone: _____ Fax: _____

Prescription Information

❑ Wegovy (semaglutide) ❑ Zepbound (tirzepatide)

❑ Initial PA Request ❑ Renewal PA Request

Strength: _____ Quantity: _____ Refills: _____

Directions for use: _____

Request Requirements:

❑ Patient does not have type 1 or 2 diabetes.

❑ Patient not concurrently using any other GLP-1 receptor agonists.

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 infraction □ Prior stroke □ Peripheral arterial disease □ Intermittent claudication with ankle-brachial index (ABI) less than 0.85 (at rest) □ Peripheral arterial revascularization procedure □ Amputation due to atherosclerotic disease
❑	❑	Patient has BMI of 27kg/m^2 or greater within the last 90 days

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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

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 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): _____