Wegovy Prior Authorization Form

Fax completed form to MedStar Family Choice-MD
1-888-243-1790 or 410-933-2274

ALL requests must be accompanied by MEDICAL RECORDS to support the request. MedStar Family Choice-Maryland MUST RENDER A DECISION WITHIN 24 HOURS. If MEDICAL RECORDS are INCOMPLETE, the request is subject to DENIAL. Return by fax to MedStar Family Choice-Maryland at: 410-933-2274

Patient Name: _____Date of Birth: _____

Patient MedStar Family Choice ID#: _____ Medicaid ID#_____

PLEASE NOTE:

- **WEGOVY MAY BE APPROVED ONLY FOR THE FOLLOWING INDICATIONS:**
  - **TO REDUCE THE RISK OF MAJOR ADVERSE CARDIOVASCULAR EVENTS (MACE), IN COMBINATION WITH A REDUCED CALORIE DIET AND INCREASED PHYSICAL ACTIVITY, FOR ADULTS WITH ESTABLISHED CARDIOVASCULAR DISEASE AND WHO ARE EITHER OBESE OR OVERWEIGHT.**
  - **TREATMENT OF NON-CIRRHOTIC METABOLIC DYSFUNCTION-ASSOCIATED STEATOHEPATITIS (MASH), WITH MODERATE TO ADVANCED LIVER FIBROSIS (CONSISTENT WITH STAGES F2 TO F3 FIBROSIS) IN ADULTS**
- **WEGOVY WILL BE APPROVED FOR 4 MONTHS FOR INITIAL REQUEST AND 6 MONTHS FOR RENEWALS**

☐ Initial Therapy.

NOTE: monthly dose escalation required to reach maintenance by time of PA renewal

☐ Continuation of Therapy.

NOTE: Patient dose must be 1.7 mg or 2.4 mg for maintenance dosing

PATIENT HISTORY

☐ Documentation in the record that the patient does **NOT** have Type 1 DM or Type 2 DM.

☐ BMI within the **last 90 days**. BMI_____ Height _____ Weight _____

☐ Documentation that this patient is **NOT** currently using any other GLP1 or GLP1/GIP combination drug (e.g., Mounjaro, Ozempic, Rybelsus, Soliqua, Trulicity, Victoza, Xultrophy, or Zepbound).

☐ Documentation that this patient is **NOT** currently using a DPP4i (alogliptin, Januvia [sitagliptin], Onglyza [saxagliptin], Tradjenta [linagliptin]).

☐ Documentation that this patient does **NOT** have the following:

- a history of confirmed pancreatitis
- suicidal thoughts or new onset depression
- current pregnancy

For MACE:

☐ Prescribed by or in consultation with a cardiologist.

☐ Documentation in the record that the patient has established atherosclerotic cardiovascular disease (ASCVD) **AND** is either obese or overweight.

☐ ASCVD documentation (check all that apply)

- ☐ Prior MI
- ☐ Prior stroke (ischemic or hemorrhagic)
- ☐ Intermittent claudication with ankle-brachial index (ABI) < 0.85
- ☐ Peripheral arterial revascularization procedure
- ☐ Amputation due to atherosclerotic disease.

For MASH:

☐ Prescribed by or in consultation with a gastroenterologist or hepatologist.

☐ Documentation of this patient's liver fibrosis stage to be F2 or F3, with testing done within the last 180 days

By signing below, I, the prescriber of Wegovy attest that:

☐ **Wegovy is being prescribed in accordance with prescribing information, including screening for any black box warnings and all contraindications.**

☐ **I have INCLUDED ALL PERTINENT MEDICAL RECORDS related to this Wegovy request.**

Prescriber Signature: _____ Date: _____

Prescriber Name/Office:_____NPI #:_____

Prescriber Address: _____

Prescriber Phone Number: _____ Prescriber Fax Number: _____

Office Contact Name: _____ Office Contact Phone: _____

Revised: December 3, 2025