AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Wegovy

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____

3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____

Mailing address: _____ City: _____ State: _____ ZIP: _____

7. Requester Contact Information: _____

Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity per 30 days: _____

11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days __Other:_____

Clinical Information

Initial Request: Wegovy for Cardioprotection

1. Are medical records attached ? Yes___ No___ ***Medical records are required for Cardioprotection prior authorization review.***

2. What is beneficiary's baseline weight and BMI? **Weight**_____ **Date**_____ **BMI**_____ **Date**_____

3. Is the beneficiary 45 years of age or older? Yes___ No___

4. Does the beneficiary have established cardiovascular disease (CVD) defined as having a history of myocardial infarction, stroke, or symptomatic peripheral arterial disease? Yes___ No___

List diagnosis: _____

5. Does the beneficiary have a personal or family history of medullary thyroid carcinoma? Yes___ No___

6. Does the beneficiary have multiple endocrine neoplasia syndrome type 2? Yes___ No___

7. Does the beneficiary have at least 3 months of lifestyle modifications prior to starting Wegovy? Yes___ No___

8. Is the beneficiary using Wegovy in combo with a reduced calorie diet and increased physical activity unless physical activity is not clinically appropriate at the time GLP1 therapy commences? Yes___ No___

Initial Request: Wegovy for NASH/MASH

1. Are medical records attached ? Yes___ No___ ***Medical records are required for NASH/MASH prior authorization review.***

2. Does the beneficiary have a diagnosis of noncirrhotic nonalcoholic steatohepatitis (NASH), or metabolic dysfunction associated steatohepatitis (MASH)? Yes___ No___

3. Does the beneficiary have a FIB-4 score consistent with stage F1, F2, or F3 fibrosis adjusted for age? Yes___ No___

4. Has the beneficiary had one of the following tests? Select which:

___ A liver biopsy
___ Vibration-controlled transient elastography (VCTE)
___ Enhanced liver fibrosis (ELF) score
___ Magnetic resonance elastography (MRE)

5. Is the beneficiary 18 years of age or older? Yes___ No___

6. What is the beneficiary's baseline BMI prior to beginning therapy? **BMI**_____ **Date**_____

7. Is the beneficiary of South Asian, Southeast Asian, or East Asian descent? Yes___ No___

8. Is the beneficiary female with alcohol consumption less than 20 grams/day? Yes___ No___

9. Is the beneficiary male with alcohol consumption less than 30 grams/day? Yes___ No___

10. Is the beneficiary being monitored for development of and/or treated for any comorbid conditions (e.g., cardiovascular disease, diabetes, dyslipidemia, hypertension)? Yes___ No___

11. Does the beneficiary have decompensated cirrhosis? Yes___ No___

12. Does the beneficiary have moderate to severe hepatic impairment (Child-Pugh Class B or C)? Yes___ No___

13. Does the beneficiary have any other liver disease? Yes___ No___ **List:** _____

14. Is Wegovy being prescribed by or in consultation with a specialist in the beneficiary's diagnosis (e.g., hepatologist, gastroenterologist)? Yes___ No___

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406

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Pharmacy Request for Prior Approval – Wegovy

Continuation Request: Wegovy for Cardioprotection and NASH/MASH

1. Are medical records attached? Yes___ No___ ***Medical records are required for prior authorization review.***
2. Has the beneficiary been previously approved for the requested agent through Medicaid's Prior Authorization process for the covered indications that went into effect 10/01/2025 [Note: beneficiaries not previously approved for the requested agent will require initial evaluation review]? Yes___ No___
3. Has medical documentation that beneficiary has improved while on the medication been included with this request? Yes___ No___
4. Are individual clinical goals set by the provider being met? Yes___ No___
5. Is the beneficiary continuing to make adequate progress towards treatment goals? Yes___ No___
6. Is the product prescribed FDA approved for the indication, age, weight (if applicable) and not exceeding dosing limits per the prescribing information per the clinical conditions for use? Yes___ No___
7. Is the beneficiary currently on and will continue lifestyle modification including structured nutrition and physical activity unless physical activity is not clinically appropriate? Yes___ No___
8. Will the beneficiary be using the requested agent with another GLP-1? Yes___ No___
9. Does the beneficiary have any FDA-labeled contraindications to the requested agent? Yes___ No___
10. Has the provider performed a review of the beneficiary's medication list for possible dose reductions or discontinuation of medications for comorbid conditions, which are no longer needed or able to be reduced due to clinical effects of receiving the medication? Yes___ No___

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

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