Reset Form Print Form

Government of District of Columbia Department of Health Care Finance

Wegovy™ (semaglutide) Prior Authorization Request

REQUEST DATE: _____

PATIENT INFORMATION

PATIENT MEDICAID ID: _____ **DATE OF BIRTH:** _____

PATIENT LAST NAME: _____

PATIENT FIRST NAME: _____ **MIDDLE INITIAL:** _____

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME: _____

PRESCRIBER FIRST NAME: _____

PRESCRIBER PHONE: _____ **PRESCRIBER FAX:** _____

PRESCRIBER DEA NUMBER: _____ **PRESCRIBER NPI NUMBER:** _____

PHYSICIAN SPECIALTY: _____

PHARMACY INFORMATION

PHARMACY NAME: _____

PHARMACY PHONE: _____ **PHARMACY FAX:** _____

PHARMACY NPI NUMBER: _____

Refer to FDA www.fda.gov for prescribing details and approved indications.

PRIOR AUTHORIZATION CRITERIA

Wegovy is covered only for indication below:

☐ To reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established cardiovascular disease and either obesity (body mass index (BMI) of ≥ 30 kg/m^2) or overweight (BMI of ≥ 27 kg/m^2)

Please note: anti-obesity drugs are excluded from coverage for the District DHCF Pharmacy Program.

- Will Wegovy be used in combination with other semaglutide-containing regimens or any other GLP-1 receptor agonist? ☐ Yes ☐ No
- Does the patient have a history of pancreatitis? ☐ Yes ☐ No
- Does the patient have a personal or family history of medullary thyroid carcinoma (MTC) or Multiple Endocrine Neoplasia syndrome type 2 (MEN 2)? ☐ Yes ☐ No
- If of childbearing potential, is the patient pregnant? ☐ Yes ☐ No

LENGTH OF AUTHORIZATION CRITERIA

Length of authorization: **up to 6 months**

FAX TO: District of Columbia Pharmacy Program
Phone: 1-800-273-4962
Fax: 1-866-535-7622

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PRIOR AUTHORIZATION RENEWAL

- Patient has met and continues to meet the initial review criteria. ☐ Yes ☐ No
- Has the patient experienced any treatment-restricting adverse effects (e.g., thyroid C-cell tumors, acute pancreatitis, acute gallbladder disease, acute kidney injury, hypoglycemia, hypersensitivity reactions, diabetic retinopathy, heart rate increase, suicidal behavior, and ideation)? ☐ Yes ☐ No
- Is dosing appropriate as per labeling or supported by compendia? ☐ Yes ☐ No

DOSAGE AND ADMINISTRATION

- Available as 0.25 mg, 0.5 mg, 1 mg, 1.7 mg, and 2.4 mg pre-filled, single-dose pen injector.
- Refer to product labeling at https://www.accessdata.fda.gov/scripts/cder/daf/

I certify that, to the best of my knowledge, all information I have provided on this request is complete and factual.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

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