South Dakota Department of Social Services

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Wegovy® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Reduce the risk of major adverse cardiovascular event (MACE) **without** diabetes
❑ Noncirrhotic metabolic dysfunction-associated steatohepatitis **without** diabetes
❑ Other diagnosis: _____ ICD-10 Code(s): _____
Not covered for obesity or weight management or Type 2 diabetes mellitus

Clinical information:

List the patient's HbA1c _____ within the last 2 months
List the patient's BMI to one decimal place (i.e., 25.1, 36.8, etc) _____

For major adverse cardiovascular event without diabetes:

1. Patient has established cardiovascular disease as evidenced by one of the following:
   a. Prior myocardial infarction ❑ Yes ❑ No List ICD-10 code(s) _____
   b. Prior stroke ❑ Yes ❑ No List ICD-10 codes _____
   c. Peripheral arterial disease ❑ Yes ❑ No List ICD-10 codes _____
2. Is the patient taking lipid-lowering and antiplatelet therapy? List drugs _____
3. Is the member a current tobacco user? ❑ Yes ❑ No
   a. If yes, did the member receive tobacco cessation counseling? ❑ Yes ❑ No

For noncirrhotic metabolic dysfunction-associated steatohepatitis without diabetes:

1. Is the patient's fibrosis stage F2 or F3? ❑ Yes ❑ No
2. Prescriber attests patient is participating in a supervised weight management plan that encourages behavioral modification, reduced calorie diet, and increased physical activity. ❑ Yes ❑ No
3. Does the patient have decompensated cirrhosis (Child-Pugh Class B or C)? ❑ Yes ❑ No
4. Select if the requested medication is prescribed by or in consultation with one of the following specialists:
   ❑ Endocrinologist ❑ Gastroenterologist ❑ Hepatologist ❑ Other _____
5. Will the medication be co-administered with another GLP-1 receptor agonist (e.g., Saxenda, Trulicity, Victoza, etc)? ❑ Yes ❑ No

If the request is for Wegovy tablets:

Has the memberhad a 90-day trial and failure of Rybelsus tablet? ❑ Yes ❑ No

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Quantity limit requests:
What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitatins?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.