

Access this PA form at: [Forms | OptumRx](#)

If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per member.

Member Information (required)			Prescriber Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	DEA#:	
Date of Birth:			Specialty:		
Street Address:			Office Phone:		Office Fax:
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
			Is the prescriber a TennCare provider with a Medicaid ID? <input type="checkbox"/> Yes <input type="checkbox"/> No		
			Is the prescriber a single-patient contract holder for this patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		

For additional details, please refer to the clinical criteria available at [Optum Rx/TennCare website](#)

Complete this Section for ALL Wegovy requests.		
<p>1. Diagnosis:</p> <p><input type="checkbox"/> Obesity Management Therapy (benefit exclusion for patient 21 years of age or older)</p> <p><input type="checkbox"/> Treatment is being requested for patients with prior myocardial infarction (MI), prior stroke (ischemic and hemorrhagic stroke), or symptomatic peripheral arterial disease (PAD) to reduce risk of major adverse cardiovascular events</p> <p>Note: Submission of medical records confirming diagnosis is required. Failure to provide the requested documentation will delay response.</p>		
<p>2. Prescriber attests that the patient is participating in a supervised comprehensive weight management program that encourages behavior modification, reduced calorie diet, and increased physical activity.</p> <p>2a. If yes, please provide name and brief overview or action plan of the comprehensive weight management program being utilized.</p> <p>_____</p> <p>_____</p> <p>_____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>3. Does the patient have any of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Diagnosis of type 1 or type 2 diabetes <input type="checkbox"/> New York Heart Association class IV heart failure <input type="checkbox"/> Personal or family history of medullary thyroid carcinoma (MTC) OR Multiple Endocrine Neoplasia syndrome type 2 (MEN 2) <input type="checkbox"/> History or presence of chronic pancreatitis <input type="checkbox"/> End-stage renal disease or currently receiving dialysis 	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
<p>4. Will the requested medication be used concurrently with another GLP-1 receptor agonists? (e.g. Byetta, Ozempic, and Victoza)</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>5. Will the requested medication be used concurrently with insulin or insulin secretagogues (e.g. sulfonylureas)?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Renewal Criteria

1. Has the patient demonstrated a positive clinical response to therapy (e.g., patient has not had a major cardiovascular event within the past 12 months, decreased body weight or waist circumference from baseline, decrease blood pressure, total cholesterol, LDL, or triglyceride levels from baseline)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Note: Valid medical documentation of a positive clinical response to therapy is required for approval.		
2. Prescriber attests that the patient does not have any contraindications or serious adverse reactions to therapy (e.g., acute gallbladder disease, acute kidney injury, acute pancreatitis).	<input type="checkbox"/> Yes	<input type="checkbox"/> No

 Prescriber Signature (required) _____
 Date
(By signature, the Physician confirms the above information is accurate and verifiable by patient records.)

Fax this form to: 1-866-434-5523
Phone: 1-866-434-5524
OptumRx will provide a response within 24 hours upon receipt.