HIGHMARK | HIGHMARK

Medication Prior Authorization Form
Fax to 1-866-240-8123

Wegovy

Member Information:

Subscriber's ID Number			Subscriber's Group Number
Member's Name		Phone	Date of Birth
Address	City	State	Zip Code

Provider Information:

Physician's Name	NPI	Phone	Fax
Address	City	State	Zip Code
Suite / Building	Physician's Signature		Date

Medication Information:

Drug Name	Drug Strength	Requested Quantity	Requested Day Supply ☐ 28 days ☐ 84 days ☐ Other: _____
Directions (Please include any plans to titrate dosing):			
Diagnosis			

Clinical Information:

1. Is the member using Wegovy in combination with a lifestyle modification program that encourages reduced calorie diet and increased physical activity (for example, nutritional counseling, participation in a comprehensive weight management program)?

   ☐ **Yes** ☐ **No**

2. Please specify how long (in months) this member has actively participated in a lifestyle modification program that encourages both a reduced calorie diet and increased physical activity (for example, nutritional counseling, participation in a comprehensive weight management program) **prior** to initiating therapy with Wegovy:

   _____ months

   ***Please attach documentation to support the answers to questions 1 and 2.**
   Acceptable forms of documentation are listed below.
   One from each category is required.

   Diet
   - Provider chart notes detailing specific dietary adjustments and/or calorie deficit
   - Recurring receipts for a subscription to a lifestyle modification program, such as Noom, Weight Watchers, Vida, Lark, Signos, Wondr, Livongo, Omada, Newtopia, Virta, plan sponsored coaching programs such as My Weight Management Journey or Penn State Health obesity medicine institute (e.g., monthly, provided for each month)
   - Dietary log maintained by member detailing specific diet and/or calorie deficit
   - Recurring appointments for private nutritional counseling or medical nutrition therapy (e.g., receipt or chart documentation provided monthly)

   Physical Activity
   - Provider chart notes specifying type, duration, and frequency of physical activity
   - Recurring receipts for a gym membership (e.g., monthly, provided for each month) and notes specifying type, duration, and frequency of physical activity
   - Summary report from a wearable device specifying frequency of physical activity (e.g., elevated heart rate for over 20 minutes for at least 3 times a week for a month)
   - Recurring appointments with a personal trainer (e.g., receipt provided monthly) and notes specifying type, duration, and frequency of physical activity)

3. Please list any weight-related comorbidities this member has, if applicable.
   ***Please attach documentation (for example, chart notes) to support this information.**

   _____

   _____

4. Please provide any weight loss medications that the member has tried and failed with dates of therapy, if applicable:

Previous weight loss medications (for example. Contrave, Saxenda, Qsymia, Xenical, Zepbound, previous Wegovy therapy, etc.)	**Dates of therapy**

5. Please provide the member's **baseline** (prior to therapy with **ANY** weight loss medication):

Height: _____ Weight: _____ Body Mass Index: _____

***Please attach documentation (for example, chart notes) to support above information.**

6. **Only fill out this section for members CURRENTLY on a weight loss medication:**

- Which weight loss medication is the member currently taking? _____
- How long has the member been on this medication?_____
- Please provide the member's **current** (while on therapy with the current weight loss medication):

Height: _____ Weight: _____ Body Mass Index: _____

***Please attach documentation (for example, chart notes) to support above information.**

7. Is the member using Wegovy with another glucagon-like peptide-1 receptor agonist or glucagon-like peptide-1 receptor agonist combinations (for example, with insulin, glucagon-like peptide-1 receptor agonist?

☐ **Yes** ☐ **No**

8. Has the member experienced therapeutic intolerance or contraindication to Zepbound (specifically, documented severe side effects from Zepbound that were not resolved by diet modification or dose de-escalation and are not anticipated to occur with Wegovy OR documented allergic reaction or hypersensitivity to Zepbound)?

☐ **Yes** ☐ **No**

9. Is Wegovy is being used for major adverse cardiovascular event risk reduction?

☐ **Yes** ☐ **No**

10. Does the member have a pre-existing diagnosis of cardiovascular disease (specifically, prior stroke or prior myocardial infarction)?

☐ **Yes** ☐ **No**

***If yes, please attach documentation (for example, chart notes) to support this information.**

11. Does the member have a pre-existing diagnosis of peripheral arterial disease?

☐ **Yes** ☐ **No**

If yes:

a. Is there documentation of any of the following?
*Please select **ALL** that apply*

☐ Intermittent claudication with ankle-brachial index (ABI) less than 0.85 at rest

☐ Peripheral arterial revascularization procedure

☐ Amputation due to atherosclerotic disease

☐ None of the above

***If peripheral arterial disease was confirmed, please attach documentation (for example, chart notes) to support this information.**

12. Does the member have a diagnosis of type 2 diabetes mellitus?

☐ **Yes** ☐ **No**

If yes:

a. Has the member experienced therapeutic failure, intolerance, or contraindication to a GLP-1 RA (glucagon-like peptide-1 receptor agonist) that is FDA-approved to treat diabetes and FDA-approved for cardiovascular risk reduction (for example, Ozempic)?

☐ **Yes** ☐ **No**

13. Does the member have a diagnosis of prediabetes?

☐ **Yes** ☐ **No**

If yes:

a. Was the member's diagnosis of prediabetes confirmed by any of the following tests within the past 6 months?

*Please select **ALL** that apply*

☐ An A1c of 5.7% to 6.4%

☐ A fasting plasma glucose (FPG) of 100 mg/dL to 125 mg/dL

☐ An oral glucose tolerance test (OGTT) of 140 to 199 mg/dL

☐ None of the above

***If prediabetes was confirmed by any of these tests, please attach documentation (for example, chart notes) to support this information.**

14. Has the member experienced therapeutic failure, contraindication, or intolerance to ezetimibe monotherapy?

☐ **Yes** ☐ **No**

15. Will the member be using Wegovy as an adjunct to a maximally-tolerated statin and ezetimibe?

☐ **Yes** ☐ **No**

16. Will the member be using Wegovy as an adjunct to a PCSK9 inhibitor (for example, Praluent, Repatha)?

☐ **Yes** ☐ **No**

17. Is the member using Wegovy as part of a plan to manage cardiovascular risk factors (for example, the member is on a statin)?

☐ **Yes** ☐ **No**

18. Is the member intolerant of statins?

☐ **Yes** ☐ **No**

If yes:

a. Has the member experienced statin-related rhabdomyolysis or skeletal-related muscle symptoms, while receiving at least two separate trials of different statins, which resolved upon discontinuation of the statins?

☐ **Yes** ☐ **No**

b. Please indicate if the member has experienced any of the following during any course of statin therapy:

i. Creatinine kinase (CK) increased to 10 times the upper limit of normal?

☐ **Yes** ☐ **No**

ii. Liver function tests (LFTs) increased to 3 times the upper limit of normal?

☐ **Yes** ☐ **No**

iii. Hospitalization due to a severe statin-related adverse event (e.g., rhabdomyolysis)?

☐ **Yes** ☐ **No**

19. Is the member currently on Wegovy and requires continued therapy?

☐ **Yes** ☐ **No**

20. Is Wegovy being used for Metabolic-Dysfunction Associated Steatohepatitis (MASH) [also known as NASH]?

☐ **Yes** ☐ **No**

*** If question 21 was answered as yes, please complete and attach documentation (for example, chart notes and test/lab results) to support information and clinical criteria in questions 22 to 31.**

21. Is Wegovy being prescribed by a gastroenterologist or hepatologist?

☐ **Yes** ☐ **No**

22. Please provide testing that was used to confirm the diagnosis of MASH (biopsy, noninvasive tests (NITs), ELF blood test, etc) along with the date of testing:

Type of testing	Date of testing

23. Please provide fibrosis staging (F0-F4):

_____

_____

24. Does this member have any of the following risk factors?
    - ☐ BMI of at least 25 kg/m^2
    - ☐ Waist circumference of at least 94 cm for males or at least 80 cm for females
    - ☐ Fasting serum glucose of at least 100 mg/dL
    - ☐ 2-hour post-prandial serum glucose of at least 140 mg/dL
    - ☐ HbA1c of at least 5.7%
    - ☐ Diagnosis of type 2 diabetes
    - ☐ Member is receiving treatment for type 2 diabetes
    - ☐ Plasma triglycerides of at least 150 mg/dL
    - ☐ Plasma HDL less than or equal to 40 mg/dL for males or less than or equal to 50 mg/dL for females
    - ☐ Member is receiving lipid lowering treatment
    - ☐ Blood pressure of at least 130/85 mmHg
    - ☐ Member is receiving treatment for hypertension

25. Is the member currently receiving standard of care pharmacologic treatment to manage comorbid diseases (for example, cardiovascular disease, dyslipidemia, diabetes, hypertension)?

☐ **Yes** ☐ **No**

26. Does this member have evidence of cirrhosis, hepatic decompensation, or hepatocellular carcinoma (HCC)?

☐ **Yes** ☐ **No**

27. Is the member's alcohol consumption less than or equal to 20 g/day in females or less than or equal to 30 g/day for males?

☐ **Yes** ☐ **No**

28. Is the member on therapy with Wegovy?

☐ **Yes** ☐ **No**

***If question 29 was answered as yes, please complete questions 30 to 31.**

29. Has the member experienced improvement or stabilization of fibrosis as demonstrated by noninvasive tests (NIT)?

☐ **Yes** ☐ **No**

30. Does the member continue to use standard of care pharmacologic treatment to manage comorbid diseases (for example, cardiovascular disease, dyslipidemia, diabetes, hypertension)?

☐ **Yes** ☐ **No**

31. Please provide any other medications that the member has tried and failed:

_____

_____

_____

_____

The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the member. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Please print, type or write legibly in blue or black ink.
3. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
4. Please provide the physician address as it is required for physician notification.
5. Fax the **completed** form and all clinical documentation to **1-866-240-8123**
   Or mail the form to: **120 Fifth Avenue, SPECARE, Pittsburgh, PA 15222**

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