

**Request for Prior Authorization
Incretin Mimetics for Non-Diabetes
Indications**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

- b. Patient has been evaluated for cardiovascular standard of care treatment; and
 - c. For Wegovy, a maintenance dose of 1.7 mg or 2.4 mg weekly is requested; and
- 2. Patient continues to use medication in combination with a reduced calorie diet and increased physical activity; and
 - 3. The requested agent will not be used in combination with other incretin mimetics.

Non-Preferred

Wegovy

Strength

Usage Instructions

Quantity

Day's Supply

Diagnosis: _____

Initial Requests:

Does patient have Type 1 or Type 2 Diabetes (attach lab results documenting current A1C or fasting plasma glucose)? Yes No

Patient has established CVD documented by one of the following (attach chart notes documenting diagnosis):

- Prior myocardial infarction
- Prior stroke (ischemic or hemorrhagic)
- Symptomatic PAD, as evidenced by:
 - Intermittent claudication with ABI less than 0.85 (at rest), or
 - Peripheral arterial revascularization procedure, or
 - Amputation due to atherosclerotic disease

Provide patient's baseline BMI: _____ Date Obtained: _____

Has patient been evaluated for cardiovascular standard of care treatment? Yes No

Will patient be using medication in combination with a reduced calorie diet and increased physical activity? Yes No

Will the requested agent be used in combination with other incretin mimetics? Yes No

Renewal Requests:

Does patient have Type 1 or Type 2 Diabetes (attach lab results documenting current A1C or fasting plasma glucose)? Yes No

Has patient been evaluated for cardiovascular standard of care treatment? Yes No

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Patient continues to use medication in combination with a reduced calorie diet and increased physical activity? Yes No

Will the requested agent be used in combination with other incretin mimetics? Yes No

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*