Wegovy (Semaglutide) Prior Authorization of Benefits Form

Texas | Medicaid

Contains confidential patient information
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 800-601-4829

1. Patient information	
Patient name:	
Patient ID number:	
Patient date of birth:	
Date of Rx:	
Patient phone number:	
Patient email address:	
2. Physician information	
Prescribing physician:	
Physician address:	
Physician phone number:	
Physician fax number:	
Physician specialty:	
Physician DEA:	
Physician NPI number:	
Physician email address:	
3. Medication	
Wegovy (Semaglutide)	
4. Strength	
5. Directions	
6. Quantity per 30 days	
Specify:	
7. Diagnosis	

1. Patient information	
8. Approval criteria: (Mark all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)	
Is the patient greater than or equal to (≥) 45 years of age?	☐ Yes ☐ No
Does the patient have a diagnosis of cardiovascular disease in the last 730 days?	☐ Yes ☐ No
Does the patient have a diagnosis of diagnosis of obesity or overweight in the last 730 days?	☐ Yes ☐ No
Does the patient have a history of pancreatitis, gastroparesis, medullary thyroid carcinoma (MTC) or multiple endocrine neoplasia syndrome type 2 (MEN 2) in the last 180 days?	☐ Yes ☐ No
Will the patient have concurrent therapy with a GLP-1 receptor agonist-containing agent?	☐ Yes ☐ No
Is the requested dose less than or equal to (≤) 4 pens per 28 days?	☐ Yes ☐ No
Does the patient have a history of an HbA1c test in the last 180 days?	☐ Yes ☐ No
Patient has failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days.	☐ Yes ☐ No

1. Patient information	
Patient has a documented allergy or contraindication to preferred agents in this class?	☐ Yes ☐ No
Patient is being treated for stage-four advanced, metastatic cancer and associated conditions?	☐ Yes ☐ No
For the Texas Medicaid *Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at: txvendordrug.com/formulary/formulary-search	
9. Physician signature	
Prescriber or authorized signature:	
Date:	
Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. 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 patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.	
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