PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS

Wegovy - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Wegovy - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Wegovy Injection (semaglutide)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: ______________________
Patient ID: ______________________
Patient Group No.: ______________________
Patient DOB: ______________________
Patient Phone:

Prescribing Physician
Physician Name: ______________________
Physician Phone: ______________________
Physician Fax: ______________________
Physician Address: ______________________
City, State, Zip: ______________________

Diagnosis: ______________________ **ICD Code:** ______________________

Comments: ______________________

Please circle the appropriate answer for each question.	
1. Is this request for continuation of therapy?	Y N
[If no, then skip to question 6.]	
2. Has the patient been successfully established on the 2.4 mg or 1.7 mg dose as maintenance therapy? If yes, please submit documentation.	Y N
[If no, then no further questions.]	
3. Is the patient continuing with lifestyle modifications and standard of care regimens (e.g., cholesterol lowering	Y N

	medication, blood pressure medication, and an antiplatelet medication)? If yes, please submit documentation.		
	[If no, then no further questions.]		
4.	Has the patient developed Type 2 Diabetes Mellitus or New York Heart Association Class IV heart failure symptoms? If yes, please submit documentation.	Y N	
	[If yes, then no further questions.]		
5.	Has the patient demonstrated adherence to Wegovy, evidenced by pharmacy claims records showing a greater than 80 percent fill rate?	Y N	
	[Note: This requirement for evidence of greater than an 80 percent fill rate may be waived if market availability of Wegovy is limited.]		
	[No further questions.]		
6.	Does the patient have established cardiovascular disease with a history of ONE of the following: A) previous mycoardial infarction (MI), B) previous stoke, C) symptomatic peripheral arterial disease (PAD) as evidenced by ANY of the following: i) intermittent claudication with ankle-brachial index (ABI) less than 0.85 (at rest), ii) peripheral arterial revascularization procedure, iii) amputation due to atherosclerotic disease? If yes, please submit documentation.	Y N	
	[If no, then no further questions.]		
7.	Does the patient have a body mass index (BMI) greater than or equal to 27 kg/m2? If yes, please submit documentation.	Y N	
	[If no, then no further questions.]		
8.	Is the patient consuming a heart healthy diet AND engaging in physical activity (at their level of ability) and will continue while on therapy with Wegovy? If yes, please submit documentation.	Y N	
	[If no, then no further questions.]		
9.	Is the patient currently receiving optimized standard of care medications for cardiovascular disease management? If yes, please submit documentation.	Y N	
	[Note: Standard of care medication regimens may include the following as appropriate: A) cholesterol lowering medication (statin, ezetimibe, fibrate, PCSK-9 inhibitor), B) blood pressure medication (beta blocker [carvedilol, metoprolol, bisoprolol], angiotensin-converting enzyme inhibitor (ACE-I) [lisinopril, etc.], angiotensin II receptor blocker (ARB) [losartan, valsartan, etc.] or angiotensin II receptor blocker neprilysin inhibitor (ARNI) [Entresto]), C) antiplatelet medication (aspirin, clopidogrel).]		
	[If yes, then skip to question 11.]		
10.	Is the patient unable to receive optimized standard of care medications for cardiovascular disease management due to the use of these medications being contraindicated? If yes, please submit documentation.	Y N	

[If no, then no further questions.]	
11. Does the patient have hypersensitivity to semaglutide or any of the inactive ingredients in Wegovy?	Y N
[If yes, then no further questions.]	
12. Does the patient have a personal or family history of medullary thyroid carcinoma (MTC)?	Y N
[If yes, then no further questions.]	
13. Does the patient have Multiple Endocrine Neoplasia syndrome type 2 (MEN 2)?	Y N
[If yes, then no further questions.]	
14. Does the patient have a diagnosis of diabetes or have a hemoglobin A1C (HgA1c) greater than 6.5 percent?	Y N
[If yes, then no further questions.]	
15. Does the patient have New York Heart Association class IV heart failure?	Y N
[If yes, then no further questions.]	
16. Will the patient be using the requested medication with other semaglutide-containing products or with another Glucagon-Like Peptide-1 (GLP-1) receptor agonist?	Y N
[If yes, then no further questions.]	
17. Is the patient using the requested medication for weight loss management?	Y N
[Note: Agents used for weight control are excluded from the benefit per COMAR.]	
[If yes, then no further questions.]	
18. Is the patient using the requested drug for any indication or use that is not FDA-approved or guideline approved?	Y N
[If yes, then no further questions.]	
19. Is the patient 45 years of age or older?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date