TRICARE Prior Authorization Request Form for
semaglutide oral tablet **(Rybelsus)**

JOHNS HOPKINS
HEALTH PLANS
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID #: _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. **Is the patient GREATER THAN or EQUAL to 18 years of age?**	☐ Yes Proceed to question **2**	☐ No **Stop** **Coverage not approved**
2. **Does the patient have a documented diagnosis of type 2 diabetes mellitus[1]?**	☐ Yes Proceed to question **3**	☐ No **Stop** **Coverage not approved**
3. **Has the patient tried and had an inadequate response to metformin, or has a contraindication to metformin?**	☐ Yes Proceed to question **4**	☐ No **Stop** **Coverage not approved**
4. **Is the patient able to adhere to the administration requirements (take on an empty stomach with no more than 4 oz. of water at least 30 min before the first meal of the day)?**	☐ Yes Proceed to question **5**	☐ No **Stop** **Coverage not approved**
5. **Is the patient a female AND pregnant?**	☐ Yes **Stop** **Coverage not approved**	☐ No Proceed to question **6**
6. **Does the patient have a history of pancreatitis?**	☐ Yes **Stop** **Coverage not approved**	☐ No Proceed to question **7**
7. **Does the patient have a personal or family history of medullary thyroid carcinoma (MTC)?**	☐ Yes **Stop** **Coverage not approved**	☐ No Proceed to question **8**
8. **Does the patient have multiple endocrine neoplasia syndrome type 2 (MEN2)?**	☐ Yes **Stop** **Coverage not approved**	☐ No Proceed to question **9**

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9. Patient and provider acknowledge that Rybelsus has not been shown to reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with type 2 diabetes mellitus and established cardiovascular disease?	☐ Yes **Sign and date below**	☐ No **Stop** **Coverage not approved**

[1] Non-FDA approved uses are not approved including weight loss (obesity) or type 1 diabetes mellitus

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[25 Aug 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: