

# Prior Authorization Request Form for semaglutide oral tablet (Rybelsus)



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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 <b>GREATER THAN</b> or <b>EQUAL</b> to 18 years of age?	<input type="checkbox"/> Yes Proceed to question <b>2</b>	<input type="checkbox"/> No <b>Stop</b> Coverage not approved
2. Does the patient have a documented diagnosis of type 2 diabetes mellitus <sup>1</sup> ?	<input type="checkbox"/> Yes Proceed to question <b>3</b>	<input type="checkbox"/> No <b>Stop</b> Coverage not approved
3. Has the patient has tried and had an inadequate response to metformin, or has a contraindication to metformin?	<input type="checkbox"/> Yes Proceed to question <b>4</b>	<input type="checkbox"/> No <b>Stop</b> 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)?	<input type="checkbox"/> Yes Proceed to question <b>5</b>	<input type="checkbox"/> No <b>Stop</b> Coverage not approved
5. Is the patient a female <b>AND</b> pregnant?	<input type="checkbox"/> Yes <b>Stop</b> Coverage not approved	<input type="checkbox"/> No Proceed to question <b>6</b>
6. Does the patient have a history of pancreatitis?	<input type="checkbox"/> Yes <b>Stop</b> Coverage not approved	<input type="checkbox"/> No Proceed to question <b>7</b>
7. Does the patient have a personal or family history of medullary thyroid carcinoma (MTC)?	<input type="checkbox"/> Yes <b>Stop</b> Coverage not approved	<input type="checkbox"/> No Proceed to question <b>8</b>
8. Does the patient have multiple endocrine neoplasia syndrome type 2 (MEN2)?	<input type="checkbox"/> Yes <b>Stop</b> Coverage not approved	<input type="checkbox"/> No Proceed to question <b>9</b>

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<b>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?</b>	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No <b>Stop</b> Coverage not approved
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<sup>1</sup> Non-FDA approved uses are not approved including weight loss (obesity) or type 1 diabetes mellitus

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

\_\_\_\_\_

Prescriber Signature Date

[19 February 2020]

<b>For Internal Use Only</b>	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: