NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services
Nebraska Medicaid Fee-For-Service Pharmacy Benefit
Prior Authorization Form Anti-Obesity Medication

If the prior authorization request is approved, payment is still subject to all general requirements, including current member eligibility, other insurance, and other program restrictions.

Member Information		
Last Name	First Name	MI
Medicaid Member ID #	Date of Birth: Age:	
Prescriber Information		
Last Name*	First Name*	MI
NPI*	NE Medicaid Provider ID	
Address		
City	State	Zip
E-mail Address		
Telephone No.*	Fax No.*	
Dispensing Pharmacy Information		
Pharmacy Name		
NPI*	NE Medicaid Provider ID	
Address		
City	State	Zip
E-mail Address		
Telephone No.*	Fax No.*	
***Required Fields**		

☐ **Semaglutide (Wegovy) is only covered for the reduction of the risk of major cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults aged 45 to 74 yrs.**

*** NDC _____ Dosing _____**

Initial Request: Initial authorization period is 6 months.

1. Does the member have a diagnosis of diabetes?
   ☐ Yes
   ☐ No

2. Does the member currently have a HgA1c ≥ 6.5 percent?
   ☐ Yes
   ☐ No

3. Does the member have one of the following? (Choose which applies)
   ☐ An initial BMI of ≥ 27 kg/m^2 and at least one weight-related comorbid condition?
   Please list the weight-related condition(s): _____
   ☐ An initial BMI of ≥ 30 kg/m^2

4. Has the member completed a weight management program medically supervised by a physician, a nurse practitioner, or a physician assistant for at least 6 months that includes all the following?

- Behavior modification, and
- Reduced calorie diet, and
- Increased physical activity

☐ Yes
☐ No

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5. Is the member *currently* on and will continue to follow all the following?

- Behavior modification; and
- Reduced calorie diet, and
- Increased physical activity, and
- Compliance with prescribed cardiovascular medications

☐ Yes
☐ No

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6. Does the member have a history of any of the following? Supporting documentation must be submitted. Choose all that apply:

☐ Prior myocardial infarction (MI)
☐ Prior stroke (ischemic or hemorrhagic)
☐ Symptomatic peripheral arterial disease (PAD) as evidenced by:

- Intermittent claudication with ankle-brachial index <0.85
- Peripheral arterial revascularization procedure, or
- Amputation due to atherosclerotic disease

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7. Does the member have any of the following? Choose all that apply:

☐ NYHA Class IV Heart failure
☐ ESRD or Dialysis
☐ History of chronic pancreatitis or presence of acute or chronic pancreatitis.
☐ Personal or first-degree relative(s) history of multiple endocrine neoplasia type 2 or medullary thyroid carcinoma
☐ Known or suspected hypersensitivity to the requested product
☐ Female who is pregnant, breastfeeding, or intends to become pregnant, or is of childbearing potential and not using a highly effective contraceptive method

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8. Will the member be using the requested product in combination with other semaglutide-containing products or any other GLP-1 receptor agonist?

☐ Yes
☐ No

Renewal: Renewal authorization period is 12 months

1. Has the member completed at least 3 months of therapy with the requested product at a stable maintenance dose?

☐ Yes
☐ No

2. Does the member have one or more of the following? Choose all that apply:

☐ Lost at least 5 percent of baseline body weight. Current weight _____ lb.
☐ Has continued to maintain their initial 5 percent weight loss

3. Is the member continuing to follow all the following?

- Behavioral modification
- A reduced calorie diet
- Increased physical activity
- Compliance with prescribed cardiovascular medications

☐ Yes
☐ No, please describe why not: _____

_____

4. Does the member *currently* have either of the following? Choose all that apply:

A diagnosis of diabetes:
☐ Yes
☐ No

HgA1c ≥ 6.5 percent:
☐ Yes
☐ No

_____

5. Will the member be using the requested product in combination with other semaglutide-containing products or any other GLP-1 receptor agonist?
☐ Yes
☐ No

_____

6. Does the member have any of the following? Choose all that apply:
   - ☐ NYHA Class IV Heart failure
   - ☐ ESRD or Dialysis
   - ☐ History of chronic pancreatitis or presence of acute or chronic pancreatitis
   - ☐ Personal or first-degree relative(s) history of multiple endocrine neoplasia type 2 or medullary thyroid carcinoma.
   - ☐ Known or suspected hypersensitivity to the product
   - ☐ Female who is pregnant, breastfeeding, or intends to become pregnant, or is of childbearing potential and not using a highly effective contraceptive method.

Prescribing Practitioner Signature: With this signature, the prescriber confirms that the information submitted above is accurate and verifiable in the patient's medical records.

Please note: The Department may request medical records to verify the information submitted above

Printed Name of Prescriber:

Signature of Prescriber (Signature of anyone else is NOT acceptable) Date Signed

Submit requests to:
Prime Therapeutics State Government Solutions, LLC

Fax: 1-866-759-4115
Telephone: 1-800-241-8335