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

Prime THERAPEUTICS

Nebraska Department of Health and Human Services
Nebraska Medicaid Fee-For-Service Pharmacy Benefit
Request for Prior Authorization – Anti-Obesity Medication
Fax this form to 866-759-4115.

Note: 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

Member Last Name: _____

Member First Name: _____

Medicaid ID: _____

Date of Birth: _____ Age: _____

PRESCRIBER INFORMATION

* Prescriber Last Name: _____

* Prescriber First Name: _____

* Prescriber NPI: _____ NE Medicaid Provider ID: _____

Physician Address: _____

City: _____ State: _____ ZIP: _____

E-mail Address: _____

* Prescriber Phone: _____ * Prescriber Fax: _____

DISPENSING PHARMACY INFORMATION

Pharmacy Name: _____

* Pharmacy NPI: _____ NE Medicaid Provider ID: _____

Pharmacy Address: _____

City: _____ State: _____ ZIP: _____

E-mail Address: _____

* Pharmacy Phone: _____ * Pharmacy Fax: _____

DRUG REQUESTED

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 years.

* NDC: _____ Dosing: _____

***Required Fields**

Member's Name: _____

INITIAL REQUEST CRITERIA

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 of 6.5 percent or greater?

   ☐ Yes ☐ No

3. Does the member have one of the following? Choose which applies.

   ☐ An initial BMI of at least 27 kg/m^2 and at least one weight-related comorbid condition

   Please list the weight-related condition(s):

   _____

   ☐ An initial BMI of at least 30 kg/m^2

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

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

   ☐ Yes ☐ No

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

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 the following:

   - Intermittent claudication with ankle-brachial index of less than 0.85
   - Peripheral arterial revascularization procedure, or
   - Amputation due to atherosclerotic disease.

Member's Name: _____

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

   ☐ NYHA Class IV heart failure

   ☐ End Stage Renal Disease (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

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 REQUEST CRITERIA

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, and
   - A reduced calorie diet, and
   - Increased physical activity, and
   - Compliance with prescribed cardiovascular medications

   ☐ Yes ☐ No

   If No, please describe why not:

   _____

4. Does the member **currently** have a diagnosis of diabetes?

   ☐ Yes ☐ No

Member's Name: _____

5. Does the member **currently** have a HgA1c of 6.5 percent or greater?

   ☐ Yes ☐ No

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

   ☐ Yes ☐ No

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

PRESCRIBING PRACTITIONER SIGNATURE

With this signature, the prescriber confirms that the information submitted above is accurate and verifiable in the member's medical records.

Note: The Department may request medical records to verify the information submitted above.

Prescriber Printed Name: _____

Prescriber Signature: _____ **Date:** _____

(Signature of anyone else is **not** acceptable.)

(With this signature, the prescriber confirms that the information above is accurate and verifiable in member records.)

Submit requests to:
Prime Therapeutics State Government Solutions, LLC
Fax: 866-759-4115
Telephone: 800-241-8335