CAREFIRST
Wegovy

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 855-582-2022 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Wegovy.

Patient Information

Patient Name:

Patient Phone: ☐☐☐-☐☐☐-☐☐☐☐

Patient ID:

Patient Group:

Patient DOB: ☐☐/☐☐/☐☐☐☐

Physician Information

Physician Name

Physician Phone: ☐☐☐-☐☐☐-☐☐☐☐

Physician Fax: ☐☐☐-☐☐☐-☐☐☐☐

Physician Addr.:

City, St, Zip:

Drug Name (select from list of drugs shown)

Wegovy (semaglutide injection)

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

_____

Please check the appropriate answer for each applicable question.

1.	Has the patient received at least 3 months of therapy with the requested drug at a stable maintenance dose?	**Y** ☐	**N** ☐
2.	Did the patient lose at least 5 percent of baseline body weight OR has the patient continued to maintain their initial 5 percent weight loss? [If yes, then documentation is required for approval.] Weight prior to Wegovy therapy: Date the weight was taken: Weight after Wegovy therapy: Date the weight was taken: _____	**Y** ☐	**N** ☐
3.	Does the patient have a body mass index (BMI) greater than or equal to 30 kilogram per square meter?	**Y** ☐	**N** ☐
4.	Does the patient have a body mass index (BMI) greater than or equal to 27 kilogram per square meter?	**Y** ☐	**N** ☐
5.	Does the patient have at least one weight-related comorbid condition (e.g., hypertension, type 2 diabetes mellitus, or dyslipidemia)?	**Y** ☐	**N** ☐
6.	Has the patient participated in a comprehensive weight management program that encourages behavioral modification, reduced calorie diet and increased physical activity with continuing follow-up for at least 6 months prior to using drug therapy?	**Y** ☐	**N** ☐
7.	Will the requested medication be used with a reduced calorie diet and increased physical activity for chronic weight management in an adult?	**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

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