PRIOR AUTHORIZATION FORM
Wegovy - Medicare

Unless otherwise indicated below, authorization quantities are limited to the manufacturer recommended dosage

Select Health
P.O. Box 30196 • Salt Lake City, UT 84130
Important Plan Information

Complete online at www.selecthealth.org/pa or fax back to: 801-650-3170 **For questions or clarifications, call: 801-442-9988 or 855-442-9988**	
Patient Information	
Patient's Name:	Patient's Date of Birth:
Patient's ID:	Patient's Phone #:
Diagnosis Code(s):	
Requesting Provider Information	
Name:	Phone #:
NPI/DEA:	Fax #:
Address:	Supervising Physician (if requesting provider bills under a different provider)
	Name:
	NPI/DEA:
Servicing Provider Information (if different than requesting provider)	
Name of provider or facility:	Phone number:
NPI/DEA:	Address:

Drug Name and Strength:	Directions / SIG:
o Urgent Request (24 hours)	o Standard Request (72 hours)

Q1. What is the patient's diagnosis?

- ☐ Established cardiovascular disease
- ☐ Noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH)
- ☐ Other

Q2. If other, please specify:

Q3. Is this a reauthorization request?

☐ Yes ☐ No

Q4. For reauthorization requests, has documentation been submitted showing the patient has responded adequately to therapy, as demonstrated by at least one of the following:

☐ Reduction in fibrosis score by at least 1 stage as determined by hepatology based on liver enzymes and FibroScan CAP

☐ MASH histological resolution

☐ None of the above

Q5. For ASCVD is the prescribing physician a Cardiologist?

☐ Yes ☐ No

Q6. Does the patient have established cardiovascular disease defined as history of any of the following?

(Please check all that apply)

☐ Prior myocardial infarction

☐ Prior stroke

☐ Symptomatic peripheral arterial disease as evidenced by intermittent claudication with ankle-brachial index greater than 0.85, peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease

☐ None of the above

Q7. Does the patient have a body mass index (BMI) of 27 or greater?

☐ Yes ☐ No

Q8. Does the patient have noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH) with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) in adults?

☐ Yes ☐ No

Q9. If yes, has the diagnosis been confirmed by transient elastography (FibroScan) CAP OR liver biopsy?

☐ Yes ☐ No

Q10. For MASH is the prescribing physician a Hepatologist or Gastroenterologist?

☐ Yes ☐ No

Q11. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q12. Will Wegovy be used in combination with another GLP-1 Receptor Agonist? (tirzepatide, dulaglutide, etc)

☐ Yes ☐ No

Q13. Does the patient's alcohol intake exceed 2 glasses per day (30g total)?

☐ Yes ☐ No

Q14. Chart Notes are required for the request of this medication. Failure to provide chart notes will result in a delay in decision and/or denial. Did you attach relevant chart notes?

☐ Yes ☐ No

Q15. Additional comments:

This form is intended for Select Health members only. All requests for preauthorization should be sent via fax to 1-801-650-3170
Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

_____ _____

Prescriber Signature Date