NC Medicaid
Pharmacy Prior Approval Request for
GLP-1's for Weight Management

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

Initial Request (Wegovy, Saxenda, and Zepbound):

1. Please list the beneficiary's baseline weight and BMI. Weight _____ Date _____ BMI _____ Date _____
2. Is the beneficiary 18 years or age or older? ☐ **Yes** ☐ **No**
   - 2a. Does the beneficiary have a BMI greater than or equal to 30 kg/m^2? ☐ **Yes** ☐ **No**
   - 2b. Does the beneficiary have a BMI greater than or equal to 27 kg/m^2? ☐ **Yes** ☐ **No**
     - 2b-i. Does the beneficiary have at least one weight-related comorbidity/risk factor/complication (i.e. hypertension, type 2 diabetes, obstructive sleep apnea, cardiovascular disease, dyslipidemia)? ☐ **Yes** ☐ **No List** _____
3. Is the beneficiary between 12-17 years or age? ☐ **Yes** ☐ **No**
   - 3a. Does the beneficiary have a BMI greater than or equal to the 95th percentile for age and sex? ☐ **Yes** ☐ **No**
   - 3b. Does the beneficiary have a BMI greater than or equal to 30 kg/m^2? ☐ **Yes** ☐ **No**
   - 3c. Does the beneficiary have a BMI greater than or equal to the 85th percentile for age and sex? ☐ **Yes** ☐ **No**
     - 3c-i. Does the beneficiary have at least one weight-related comorbidity/risk factor/complication (i.e. hypertension, type 2 diabetes, obstructive sleep apnea, cardiovascular disease, dyslipidemia)? ☐ **Yes** ☐ **No List** _____
4. Is the beneficiary age 45 years of age or older? ☐ **Yes** ☐ **No**
   - 4a. Does the beneficiary have a BMI greater than or equal to 27 kg/m^2? ☐ **Yes** ☐ **No**
     - 4a-i. Does the beneficiary have established cardiovascular disease (CVD) defined as having a history of myocardial infarction, stroke, or symptomatic peripheral disease? ☐ **Yes** ☐ **No List** _____
5. Is the beneficiary currently on and will the beneficiary continue lifestyle modification including structured nutrition and physical activity, unless physical activity is not clinically appropriate at the time GLP1 therapy commences? ☐ **Yes** ☐ **No**
6. Will the beneficiary be using the requested agent with another GLP-1? ☐ **Yes** ☐ **No**
7. Does the beneficiary have any FDA-labeled contraindications to the requested agent, including pregnancy, lactation, history of medullary thyroid cancer or multiple endocrine neoplasia type II? ☐ **Yes** ☐ **No**

Continuation Request (Wegovy, Saxenda, and Zepbound):

8. Has the beneficiary previously been approved for the requested agent through NC Medicaid's PA process? ☐ **Yes** ☐ **No**
9. Beneficiary's baseline and current weight. Baseline Wt. _____ Date _____ Current Weight _____ Date _____
10. Beneficiary's baseline and current BMI. Baseline BMI _____ Date _____ Current BMI _____ Date _____
11. Is the beneficiary continuing a current weight loss course of therapy? ☐ **Yes** ☐ **No**
12. **Ages 18 and older-** Has the beneficiary lost a total of 5% of pretreatment weight and is maintaining the 5% weight loss? ☐ **Yes** ☐ **No** Baseline Weight _____ Current Weight _____
13. **Ages (≥12 to <18 years)** – Has the beneficiary had >4% reduction in baseline BMI and is maintaining the weight loss? ☐ **Yes** ☐ **No** Baseline Weight _____ Current Weight _____
14. Does the beneficiary have a documented weight loss that is deemed to be a significant reduction from BMI per the prescriber and the weight loss is maintained, yet the 5% (for adults) and 4% (for adolescents) is not met? ☐ **Yes** ☐ **No**

Rationale _____

Fax this form to 1-866-940-7328

Pharmacy PA Call Center: 1-855-258-1593

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15. Is the beneficiary currently on and will continue lifestyle modification including structured nutrition and physical activity?
☐ **Yes** ☐ **No**
16. Will the beneficiary be using the requested agent with another GLP-1? ☐ **Yes** ☐ **No**
17. Does the beneficiary have any FDA-labeled contraindications to the requested agent, including pregnancy, lactation, history of medullary thyroid cancer or multiple endocrine neoplasia type II? ☐ **Yes** ☐ **No**

Request for Non-Preferred Drug (Saxenda, and Zepbound):

1. Failed preferred drug(s). List preferred drugs failed: _____
   1a. ☐ Allergic Reaction 1b. ☐ Drug-to-drug interaction. Please describe reaction: _____
2. Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information:
   _____
   _____
3. Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s). Please provide clinical information: _____
4. Age specific indications. Please give patient age and explain: _____
5. Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a general reference:
   _____
6. Unacceptable clinical risk associated with therapeutic change. Please explain: _____
   _____

Signature of Prescriber: _____ Date: _____
(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

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