STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
PO BOX 2943 HARTFORD, CT 06104
TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110

CT Medical Assistance Program *WEGOVY* for MACE (Major Adverse Cardiovascular Events) Prior Authorization (PA) Request Form

[This and other pharmacy PA forms are available at www.ctdssmap.com]

To Be Completed By Prescriber

Prescriber Information	Patient Information
Prescriber's NPI:	Member's Name (Last, First)
Prescriber's Name:	Member's ID
Phone #	Member's Date of Birth (MMDDCCYY)
Fax #	Requested Wegovy Strength

Criteria for Medical Necessity Review

Section 1 Initial Wegovy Request		
1.) Patient is 18 years of age of older?	☐ Yes	☐ No
2.) **Is the patient diagnosed with type 1 or type 2 diabetes, or NY Heart Association class IV heart failure?	☐ Yes**	☐ No
3.) Is patient's Hemoglobin A1c less than 6.5%?	☐ Yes	☐ No
4.) Is patient's Body Mass Index (BMI) greater than or equal to 27?	☐ Yes	☐ No
5.) Does the patient have established cardiovascular disease with ONE of the following: a.) History of myocardial infarction. **Provide date of event**: _____ b.) History of ischemic or hemorrhagic stroke. **Provide date of event**: _____ c.) Symptomatic peripheral arterial disease. **Provide one of the following** • Ankle-brachial index: _____ • Date of amputation due to atherosclerotic disease: _____ • Date of peripheral arterial revascularization procedure: _____	☐ Yes	☐ No
6.) Does the patient's treatment of plan include active participation in comprehensive adjunct lifestyle interventions (e.g. diet modifications, physical activity, behavioral therapy)?	☐ Yes	☐ No

****If Question 2 in Section 1 (Initial request) is answered as a "Yes," or if questions 1, 3, 4, 5 and 6 are answered as "No," the product is not covered. A Letter of Medical Necessity (LMN) must be reviewed for consideration. Please provide all relevant information relating to medical necessity (see Conn. Gen. Stat 17b-259b (a)) for this patient. Submit request, via email, to rx.lmn@ct.gov**

Section 2 Subsequent Requests for Wegovy Continuation		
1.) Has the patient previously met the required criteria set forth in Section 1 above (Initial Medication Request)? a.) Prior Approved Prior Authorization Number: _____ Date: _____	☐ Yes	☐ No
2.) Does patient continue to participate in comprehensive adjunct lifestyle intervention plan? (e.g. Diet Modifications, Physical Activity, Behavioral Therapy)	☐ Yes	☐ No
3.) Has there been a weight loss of at least 5% from baseline?	☐ Yes	☐ No

If you answered "No" to any questions in Section 2 (Continuation request) the product is not covered. A Letter of Medical Necessity (LMN) must be reviewed for consideration. Please provide all relevant information relating to the medical necessity (see Conn. Gen. Stat. § 17b-259b(a)) of this drug for this patient. Submit request, via email, to rx.lmn@ct.gov

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.

I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under Connecticut Gen. Stat. Section 17b- 99 and Regs. Conn. State Agencies Sections 17-83k-1-3 and 4a – inclusive. I certify that the client is under my clinic's/practice's ongoing care. I understand that Prior Authorizations will not exceed 6 months from date of fill for controlled medications and 1 year for non-controlled medications/products, except for Early Refill Requests, which are valid one time only.

Prescriber Signature: _____ Date: _____

* Mandatory (others may not sign for prescriber). In accordance to mandates set forth in the Affordable Care Act (ACA), providers who order, prescribe, or refer clients for services must be enrolled in the Connecticut Medical Assistance Program (CMAP). Effective 10/1/2013, any prescriptions or services provided by a non-enrolled provider will no longer be considered/covered by CMAP.