STATE OF CONNECTICUT DEPARTMENTOF SOCIAL SERVICES
TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110

WEGOVY for MASH (Metabolic Dysfunction-Associated Steatohepatitis)

Prior Authorization (PA) Request Form

CT Medical Assistance Program

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

MASH Criteria for Medical Necessity Review

Section 1 Initial Wegovy Request		
1.)	Patient is 18 years of age or older?	☐ Yes ☐ No
2.)	Patient's Hemoglobin A1c is less than 9.5%?	☐ Yes ☐ No
3.)	Patient has histologically documented steatohepatitis? a.) What is the patient's liver fibrosis stage? (F0 - F4) _____	☐ Yes ☐ No
4.)	Patient's NAFLD Activity Score (NAS) greater than or equal to 4?	☐ Yes ☐ No
5.)	Are the following statements **ALL** true? a.) Patient is free from other causes of chronic liver disease, apart from MASLD **AND** b.) Patient currently consumes less than 20g of alcohol per day for women **OR** 30g per day for men **AND** c.) Patient has a hepatic decompensation or Model for End-Stage Liver Disease (MELD) score of less than or equal to 12 points **AND** d.) Patient's AST and ALT levels are less than or equal to 5 times upper limit of normal.	☐ 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 questions 1 through 6 are answered as "No," or if the patients liver fibrosis stage is not F2 or F3, 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**

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.