



**NC Medicaid
Pharmacy Prior Approval Request for
GLP-1's Wegovy and Zepbound**

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 Other _____

Clinical Information

Initial Request: Wegovy for Cardioprotection

- 1.. Does the beneficiary have a documented baseline BMI of $\geq 27\text{kg}/\text{m}^2$ prior to beginning therapy? **Yes** **No**
BMI _____ Date _____
2. Is the beneficiary 45 years of age or older? **Yes** **No**
3. Does the beneficiary have established cardiovascular disease (CVD) defined as having a history of myocardial infarction, stroke, or symptomatic peripheral arterial disease? **Yes** **No** List diagnosis _____
(medical records required)
4. Does the beneficiary have a personal or family history of medullary thyroid carcinoma? **Yes** **No**
5. Does the beneficiary have multiple endocrine neoplasia syndrome type 2? **Yes** **No**

Initial Request Wegovy for NASH/MASH

1. Does the beneficiary have a diagnosis of noncirrhotic nonalcoholic steatohepatitis (NASH) or metabolic dysfunction associated steatohepatitis (MASH)? **Yes** **No (medical records required)**
2. Does the beneficiary have a FIB-4 score consistent with stage F1, F2, or F3 fibrosis adjusted for age? **Yes** **No** List Score _____
3. Has the beneficiary had one of the following tests? (check)
 A liver biopsy
 Vibration-controlled transient elastography (VCTE)
 Enhanced liver fibrosis (ELF) score
 Magnetic resonance elastography (MRE)
4. Is the beneficiary 18 years old or over? **Yes** **No**
5. What is the beneficiary's baseline BMI prior to beginning therapy? BMI _____ Date _____
6. Is the beneficiary being monitored for development of and/or treated for any comorbid conditions (e.g., cardiovascular disease, diabetes, dyslipidemia, hypertension) ? **Yes** **No**
7. Does the beneficiary have decompensated cirrhosis? **Yes** **No**
8. Does the beneficiary have moderate to severe hepatic impairment (Child-Pugh Class B or C)? **Yes** **No**
9. Does the beneficiary have any other liver disease? **Yes** **No** List _____

Continuation Request: Wegovy for cardioprotection and for NASH/MASH

1. Has the beneficiary been previously approved for the requested agent through Medicaid's Prior Authorization process on or after 10/01/2025 for cardioprotection or NASH/MASH based on FDA indications for these medications? [Note: beneficiaries not previously approved for the requested agent will require initial evaluation review]? **Yes** **No**
2. Has medical documentation that beneficiary has improved while on the medication been included with this request? **Yes** **No**
3. Are individual clinical goals set by the provider being met? **Yes** **No**
4. Is the beneficiary continuing to make adequate progress towards treatment goals? **Yes** **No**



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Pharmacy Prior Approval Request for

- 5. Is the product prescribed FDA approved for the indication, age, weight (if applicable) and not exceeding dosing limits per the prescribing Information per the clinical conditions for use? 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? Yes No

Initial Request: Zepbound for Sleep Apnea

- 1. Is the beneficiary 18 years old or older? Yes No
- 2. Does the beneficiary have Moderate to Severe Obstructive Sleep Apnea (OSA) with obesity? Yes No (medical records required)
- 3. Does the beneficiary have a documented baseline BMI of $\geq 30\text{kg/m}^2$ prior to beginning therapy? Yes No
BMI _____ Date _____
- 4. Is Zepbound prescribed in accordance with the FDA approved indications, age, weight (if applicable) and not exceed dosing limits per the prescribing Information per the clinical conditions for use? Yes No
- 5. Will the beneficiary be using the requested agent in combination with another GLP-1 receptor agonist agent? Yes No
- 6. 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
- 7. Is documentation attached to this request confirming that sleep apnea testing was performed and sleep apnea was diagnosed?
 Yes No

Continuation Request Zepbound for Moderate to Severe Sleep Apnea:

- 1. Has the beneficiary been previously approved for the requested agent through Medicaid's Prior Authorization process on or after 10/01/2025 for Moderate to Severe Obstructive Sleep Apnea based on FDA indications for this medication? [Note: beneficiaries not previously approved for the requested agent will require initial evaluation review]? Yes No
- 2. Has medical documentation that beneficiary has improved while on the medication been included with this request? Yes No
- 3. Are Individual clinical goals set by the provider being met? Yes No
- 4. Is the beneficiary continuing to make adequate progress towards treatment goals? Yes No
- 5. Is Zepbound FDA approved for the indication, age, weight (if applicable) and does not exceed dosing limits per the Prescribing Information per the clinical conditions for use? 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? Yes No

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.