



**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/m²? Yes No
2b. Does the beneficiary have a BMI greater than or equal to 27 kg/m²? 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/m²? 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/m²? 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 _____



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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.