



**PRIOR AUTHORIZATION REQUEST FORM**  
Individual and Family Plans

**Wegovy**

**Fax back to: (833) 605-4407**

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: <input type="checkbox"/> Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	<b>Specialty/facility name (if applicable):</b>

**REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

**Please attach any pertinent medical history including labs and information for this member that may support approval.**

**Please answer the following questions and sign.**

<p><b>Q1. Is the drug requested being used for weight loss ONLY?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Q2. Is the request for renewal? If YES, go to 3. If NO, go to 7.</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Q3. Does the patient continue to follow a reduced-calorie diet and increased physical activity plan?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Q4. Has the patient had a 5% reduction in body weight from baseline (confirm recent body weight)?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Q5. Is the patient adherent to Wegovy based on claims history?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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<b>Patient Name:</b>	<b>Prescriber Name:</b>
Q6. Does the patient continue to take optimized pharmacotherapy for established cardiovascular disease?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Is the patient 18 years of age or older?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Has the patient had a prior myocardial infarction?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Has the patient had a prior stroke?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Does the patient have a history of peripheral arterial disease evidenced by one of the following: A) Intermittent claudication with ankle-brachial index <0.85, B) Peripheral arterial revascularization procedure, C) Amputation due to atherosclerotic disease ?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q11. Does the patient have a BMI greater than or equal to 27 kg/m2 (attach baseline body weight and BMI)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q12. Will the medication be used in combination with optimized pharmacotherapy for established cardiovascular disease?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q13. Will the patient follow a reduced-calorie diet and increased physical activity plan?	



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<b>Patient Name:</b>	<b>Prescriber Name:</b>
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q14. Additional Information:	

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

v2025