Jefferson Health Plans

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.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ 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.

Q1. Is the drug requested being used for weight loss ONLY?

☐ Yes ☐ No

Q2. Is the request for renewal? If YES, go to 3. If NO, go to 7.

☐ Yes ☐ No

Q3. Does the patient continue to follow a reduced-calorie diet and increased physical activity plan?

☐ Yes ☐ No

Q4. Has the patient had a 5% reduction in body weight from baseline (confirm recent body weight)?

☐ Yes ☐ No

Q5. Is the patient adherent to Wegovy based on claims history?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Does the patient continue to take optimized pharmacotherapy for established cardiovascular disease?

☐ Yes ☐ No

Q7. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q8. Has the patient had a prior myocardial infarction?

☐ Yes ☐ No

Q9. Has the patient had a prior stroke?

☐ Yes ☐ 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 ?

☐ Yes ☐ No

Q11. Does the patient have a BMI greater than or equal to 27 kg/m2 (attach baseline body weight and BMI)?

☐ Yes ☐ No

Q12. Will the medication be used in combination with optimized pharmacotherapy for established cardiovascular disease?

☐ Yes ☐ No

Q13. Will the patient follow a reduced-calorie diet and increased physical activity plan?

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q14. Additional Information:	

Prescriber Signature _____ Date _____

v2025