

**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 ☐ Other _____

Clinical Information * Submit clinical documentation that supports the answers listed below for review *

Initial Request: Wegovy for Cardioprotection

1. Please list the beneficiary's baseline weight and BMI. Weight _____ Date _____ 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 _____
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
6. Does the beneficiary have at least 3 months of lifestyle modifications prior to starting Wegovy? ☐ Yes ☐ No
7. Is the beneficiary using Wegovy in combo with a reduced calorie diet and increased physical activity unless physical activity is not clinically appropriate at the time GLP1 therapy commences? ☐ 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 of South Asian, Southeast Asian, or East Asian descent? ☐ Yes ☐ No
7. Is the beneficiary female with alcohol consumption less than 20 grams/day? ☐ Yes ☐ No
8. Is the beneficiary male with alcohol consumption less than 30 grams /day? ☐ Yes ☐ No
9. Is the beneficiary being monitored for development of and/or treated for any comorbid conditions (e.g., cardiovascular disease, diabetes, dyslipidemia, hypertension)? ☐ Yes ☐ No
10. Does the beneficiary have decompensated cirrhosis? ☐ Yes ☐ No
11. Does the beneficiary have moderate to severe hepatic impairment (Child-Pugh Class B or C)? ☐ Yes ☐ No
12. Does the beneficiary have any other liver disease? ☐ Yes ☐ No List _____
13. Is Wegovy being prescribed by or in consultation with a specialist in the area of the beneficiary's diagnosis (e.g., hepatologist, gastroenterologist)? ☐ Yes ☐ No

Continuation Request: Wegovy for cardioprotection and for NASH/MASH

NC Medicaid Pharmacy Prior Approval Request for

1. Has the beneficiary been previously approved for the requested agent through Medicaid's Prior Authorization process for the covered indications that went into effect 10/01/2025 [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 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. Is the beneficiary currently on and will continue lifestyle modification including structured nutrition and physical activity unless physical activity is not clinically appropriate? ☐ **Yes** ☐ **No**
7. Will the beneficiary be using the requested agent with another GLP-1? ☐ **Yes** ☐ **No**
8. Does the beneficiary have any FDA-labeled contraindications to the requested agent? ☐ **Yes** ☐ **No**
9. Has the provider performed a review of the beneficiary's medication list for possible dose reductions or discontinuation of medications for comorbid conditions, which are no longer needed or able to be reduced due to clinical effects of receiving the medication? ☐ **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**
3. Does the beneficiary have a documented baseline BMI of $\geq 40\text{kg}/\text{m}^2$ 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. Is the beneficiary currently on and will 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 in combination with another GLP-1 receptor agonist agent? ☐ **Yes** ☐ **No**
7. Does the beneficiary does 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**
8. Is documentation attached to this request confirming that sleep apnea testing was performed and sleep apnea was diagnosed?
☐ **Yes** ☐ **No**
9. Has the beneficiary been instructed on sleep hygiene modifications before beginning Zepbound (for example, sleep positioning to avoid a non-supine position, avoidance of alcohol and stimulants before bed)? ☐ **Yes** ☐ **No**

Continuation Request Zepbound for Sleep Apnea:

1. Has the beneficiary been previously approved for the requested agent through Medicaid's Prior Authorization process for the covered indications that went into effect 10/01/2025? 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 not exceed dosing limits per the Prescribing Information per the clinical conditions for use? ☐ **Yes** ☐ **No**
5. Is the beneficiary currently on and will continue lifestyle modification including structured nutrition and physical activity unless physical activity is not clinically appropriate? ☐ **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**
8. Has the provider performed a review of the beneficiary's medication list for possible dose reductions or discontinuation of medications for comorbid conditions, which are no longer needed or able to be reduced due to clinical effects of the medication?
☐ **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.