United Healthcare Community Plan

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

GLP1 Receptor Agonists for Metabolic Dysfunction-Associated Steatohepatitis (MASH)

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

For initial requests, continue below. For renewal requests, proceed to Length of Authorization. If approved, initial authorizations are granted for 6 months. Renewal authorizations are granted for 12 months.

Drug Name: _____ **Drug Form:** _____

Drug Strength: _____ **Dosing Frequency:** _____

Length of Therapy: _____ **Quantity:** _____

Day Supply: _____

- **FDA indicated medications only.**
- **Must be prescribed by or in consultation with a hepatologist or gastroenterologist or other provider specializing in liver disease for the member to receive authorization.**

Please include all requested information and answer all questions on the following pages of this form. Incomplete forms will delay the SA process. If the provider is unable to attest to all of the following, a denial of coverage will be rendered.

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

Select applicable diagnosis and medical information below:

☐ The member 18 years of age or older; **AND**

☐ The member has a diagnosis of MASH with results of baseline liver biopsy or noninvasive tests demonstrating the presence of stage F2 or F3 fibrosis by at least **one** of the following:

- ☐ Liver biopsy; **OR**
- ☐ Noninvasive tests (such as transient elastography, Fibroscan, or magnetic resonance elastography) performed within the last 6 months; **AND**

☐ The member has a BMI ≥ 18.5 kg/m^2; **AND**

☐ The provider attests that the member received individualized healthy lifestyle counseling; **AND**

☐ The member does not have an A1C of > 9.5%; **AND**

☐ The member does not have known or suspected excessive consumption of alcohol according to the CDC' guidance; **AND**

☐ The member does not have hepatic decompensation or a MELD score of > 12 at screening; **AND**

☐ The member does not have pancreatitis, acute suicidal behavior/ideation, personal or family history of medullary thyroid cancer or multiple endocrine neoplasia 2 syndrome; **AND**

☐ The member is not concurrently on another GLP-1 receptor agonist

☐ Check if additional documents will be uploaded

LENGTH OF AUTHORIZATION

Renewal request (see additional requirements below):

☐ The member has experienced clinical improvement on the requested medication

☐ The member is being treated with a maintenance dosage of the requested drug

Prescriber Signature (Required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records. Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center 1-800-310-6826