VERMONT

Department of Vermont Health Access
NOB 1 South, 280 State Drive
Waterbury, Vermont 05671-1010

Semaglutide: MACE Reduction

Prior Authorization Request Form

For members to receive Medicaid coverage for medications that require prior authorization, the prescriber must complete and fax this form to Optum. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Optum helpdesk at 1-844-679-5363.

Submit request via Fax: 1-844-679-5366

Prescribing physician:
Name: _____
Physician NPI: _____
Specialty: _____
Phone#: _____
Fax#: _____
Address: _____
Contact Person at Office: _____

Beneficiary:
Name: _____
Medicaid ID#: _____
Date of Birth: _____Sex: _____
Patient's Phone: _____
Pharmacy Name_____
Pharmacy NPI: _____
Pharmacy Phone: _____Pharmacy Fax: _____

Drug Requested: _____
Strength/Route/Frequency: _____ Length of Therapy:_____

Medical Necessity Documentation Required: (Attach copies of supporting office notes.)

Is this medication being used for weight loss only? ❑ Yes ❑ No
(Per policy Vermont does not allow coverage for weight loss products)

Is the patient an adult with BMI > 27kg/m^2 ❑ Yes ❑ No

Does the patient have:

- At least one of the following comorbidities*: history of stroke, MI, or symptomatic PAD ❑ Yes ❑ No
  **Require documentation through submission of chart notes*
- End stage renal disease or dialysis ❑ Yes ❑ No
- NYHA class IV heart failure ❑ Yes ❑ No

Have you obtained current A1C level? ❑ Yes ❑ No

- Is patient diabetic? ❑ Yes ❑ No
  If yes, please list medication the patient has tried: _____

Is the patient concurrently taking a lipid-lowering agent? ❑ Yes ❑ No

Has the received counseling on chronic weight management (increased physical activity and a reduced calorie diet? ❑ Yes ❑ No

Renewal Requests (Clinical notes documenting member's response to therapy must be submitted)

Has the patient continued to follow a reduced calorie diet and increased physical activity plan? ❑ Yes ❑ No

Has the patient shown a documented weight loss ≥ 5% of baseline body weight or continued to maintain initial 5% weight loss? ❑ Yes ❑ No

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

Provider Signature: _____Date of Submission: _____
***MUST MATCH PROVIDER LISTED ABOVE**