Print Reset

NYRx, the Medicaid Pharmacy Program
Wegovy® Prior Authorization Request Form

Fax form to 1-800-268-2990 | Requests are responded to within 24 hours

INSTRUCTIONS

Refer to the drug utilization review section on the NYRx Preferred Drug List (PDL) for Wegovy® clinical criteria requirements. Please fill out all sections completely and legibly.

MEMBER INFORMATION

Member Last Name: _____

Member First Name: _____

Member Medicaid ID (two letters, five numbers, one letter): _____

Date of Birth (MM/DD/YYYY): _____ Sex: ☐ Male ☐ Female ☐ X

Height (in/cm): _____ Weight (lb/kg): _____ BMI (kg/m^2): _____

Allergies: _____

Is the member transitioning from a facility? ☐ Yes ☐ No

If **Yes**, provide facility name: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Prescriber NPI: _____ Specialty: _____

Prescriber Street Address: _____

City: _____ State: _____ Zip: _____

Prescriber Phone: _____ Prescriber Fax: _____

Prescriber's Authorized Agent: _____

Note: An authorized agent is an employee of the prescriber who has access to the member's medical records and is submitting this form on the prescriber's behalf. PA requests submitted by third parties will not be accepted.

MEDICATION AND DISPENSING INFORMATION

Drug Name: _____ Drug Strength: _____

Drug Formulation: _____ Dosing Frequency: _____

Quantity: _____ Day Supply: _____

Revision Date: 10/30/25

Member Last Name: _____ Date of Birth (MM/DD/YYYY): _____

Select one of the following:

☐ New medication therapy

☐ Renewal of medication therapy previously covered by NYRx

☐ Same dose and frequency

Approximate date therapy initiated (MM/DD/YYYY): _____

☐ New strength or frequency

Prior dosage or frequency: _____

Approximate date therapy initiated (MM/DD/YYYY): _____

☐ Continuation of therapy from other/previous insurer

Prior dosage or frequency: _____

Approximate date therapy initiated (MM/DD/YYYY): _____

BMI at start of therapy (kg/m^2): _____

Note: If continuing from other/previous insurer and it is the first time requesting a prior authorization via NYRx, CLINICAL CRITERIA: INITIATION OF THERAPY must also be answered.

CLINICAL CRITERIA

1. What diagnosis is this being prescribed for?

   Diagnosis #1: _____ ICD-10 Code: _____

   Diagnosis #2: _____ ICD-10 Code: _____

2. Does the member have type 1 or type 2 diabetes mellitus?

   ☐ Yes ☐ No

3. Does the member have established cardiovascular disease?

   ☐ Yes ☐ No

   If **Yes**, provide the specific cardiovascular diagnosis:

   _____

4. Is the member using any other GLP-1 agonist therapy at this time?

   ☐ Yes ☐ No

Member Last Name: _____ Date of Birth (MM/DD/YYYY): _____

CLINICAL CRITERIA: INITIATION OF THERAPY

5. What is the member's BMI at the initiation of therapy (kg/m^2):_____
6. Is the member adherent to established prescribed cardiovascular disease (CVD) therapy (antihypertensive, lipid-lowering agent, and anti-thrombotic agent, or platelet aggregation inhibitor) for at least six months prior to initiating therapy?

   ☐ Yes ☐ No

   If **Yes**, provide the current CVD therapy:

   _____

   If **No**, provide the clinical rationale:

   _____

7. Does the prescriber attest that the member has participated in comprehensive lifestyle modifications that encourage behavioral modifications, a reduced calorie diet and increased physical activity starting at least six months prior to initiating therapy and with continued treatment?

   ☐ Yes ☐ No

   If **No**, provide the clinical rationale:

   _____

8. Does the prescriber attest that the member will continue comprehensive lifestyle modifications that encourage behavioral modifications, a reduced calorie diet and increased physical activity?

   ☐ Yes ☐ No

   If **No**, provide the clinical rationale:

   _____

Member Last Name: _____ Date of Birth (MM/DD/YYYY): _____

CLINICAL CRITERIA: CONTINUATION OF THERAPY

9. Has the member been adherent to Wegovy?

   Note: Adherent to Wegovy is defined as consistent use with no lapses in therapy via NYRx and/or any previous insurer.

   ☐ Yes ☐ No

   If **No**, provide the clinical rationale:

10. Does the member remain adherent to established prescribed CVD therapy (antihypertensive, lipid-lowering agent, and anti-thrombotic agent, or platelet aggregation inhibitor)?

    ☐ Yes ☐ No

    If **Yes**, provide documentation of current CVD therapy:

    If **No**, provide the clinical rationale:

11. Has the member attempted to use Wegovy for the reduction of MACE (major adverse cardiovascular events) two or more times in their lifetime?

    ☐ Yes ☐ No

    If **Yes**, provide the clinical rationale:

Submission of this form confirms the information is accurate and true, and that the supporting documentation is available for review upon request of the New York State Department of Health or the Centers for Medicare & Medicaid Services. The submitter understands that any person who knowingly makes or causes to be made a false record to statement that is material to a Medicaid claim may be subject to civil penalties and treble damages under both the federal and New York State False Claims Acts.

Fax the completed form to the NYRx Clinical Call Center at 1-800-268-2990.

To contact the NYRx Clinical Call Center, call 1-877-309-9493.

For the NYRx Preferred Drug List (PDL), visit https://newyork.fhsc.com/providers/pdl.asp.