Semaglutide (Wegovy) for Weight Loss Prior Authorization Form
Florida AIDS Drug Assistance Program

Instructions:

- Fax completed form and documentation to ADAP confidential fax line at 850-412-2680.
- For any questions regarding this form, please contact the HIV Medical Team via email at HIVMedicalTeam@flhealth.gov.

Note: Prescriber will receive a response via fax within seven business days.

PATIENT LAST NAME:	**PATIENT FIRST NAME:**	**DATE OF BIRTH:**
PRESCRIBER NAME (first and last):		
CREDENTIALS: ☐ **APRN**	☐ **DO** ☐ **MD** ☐ **PA**	
PRESCRIBER PHONE:	**PRESCRIBER FAX:**	
PRESCRIBER EMAIL:		
OFFICE CONTACT NAME /NUMBER:		

COVERAGE FOR INSURED CLIENTS ONLY ***Select one of the options below.***	
☐	Patient's insurance will be the primary payor and ADAP will cover copay only • Submission of this form is not required. • **You will be contacted to provide information, if needed, before *a coverage determination is made.***
☐	Patient's insurance has denied coverage and ADAP will be the sole payor • Document whether semaglutide was denied due to being non-formulary or denied for clinical reasons. • Submit documentation of insurance denial for semaglutide. • **Complete remainder of this form and submit as instructed above.**

SEMAGLUTIDE CRITERIA FOR USE • **The criteria below must be met for the patient to be eligible to receive semaglutide as a weight loss agent through Florida ADAP.**	
☐	BMI > 40 (morbidly obese) or BMI 37-39.9 with ≥1 weight-related comorbidity, or BMI 33-36.9 with 2 or more weight-related comorbidities BMI: _____ Weight-related comorbidities: ☐ Hypertension ☐ Type 2 diabetes mellitus ☐ Dyslipidemia ☐ OSA ☐ Other (specify): _____

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☐	Trial of diet and exercise (minimum 12 months) with no weight loss noted
☐	No personal or family history of medullary thyroid carcinoma or Multiple Endocrine Neoplasma syndrome type 2
Submit the following information to be used to determine whether semaglutide can be approved for your patient:	
Reason for insurance denial? Has an appeal to the insurance been made? If no, why not?	
List any comorbidities (if not already listed above):	
Describe exercise regimens tried and duration for each (document pre and post weights) If none, list reason (i.e. injury etc.)	
List diets tried, and length of time for each (document pre and post weights):	
Previous weight-loss medications tried and failed (including start/stop dates):	
List any psychiatric history:	
List any pancreatic history (e.g., pancreatitis):	
If approved, the prescriber must agree to the following:	
☐	Patient will sign a statement agreeing to continue with dietary and exercise measures while on treatment.
☐	Submission of weight documented at clinic visits for 6 months after starting semaglutide Note: If there is no significant weight loss after 6 months of being on the highest dose, we will consider discontinuing payment for the medication.

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☐ **I understand that ADAP may rescind the approval for semaglutide (with prior provider notice) for any reason (e.g., patient is not responding adequately, patient is not adherent, fiscal constraints)**			
PRESCRIBER SIGNATURE:		**Date:**	
ADAP USE ONLY			
CLIENT ID NUMBER:		**Date Request Received:**	
Request Approved:	☐ Yes ☐ No	**Reviewed by:**	