Louisiana Medicaid
Semaglutide (Wegovy®)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for Wegovy®. For initiation of therapy requests, the *Semaglutide (Wegovy®) Treatment Agreement for Louisiana Medicaid Recipients* must be completed as instructed, and submitted with the request form.

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

Approval Criteria for Specific Diagnoses:

Established Cardiovascular (CV) Disease (Wegovy Injection or Tablet)

Approval Criteria for Initiation of Therapy

- The recipient is 45 years of age or older on the date of the request; **AND**
- The **date and results of the most recent BMI calculation are stated on the request** showing:
  - The recipient has a documented Body Mass Index (BMI) of ≥ 27 kg/m^2 and < 35 kg/m^2; **OR**
  - The recipient has a documented BMI ≥ 35 kg/m^2, and documentation of evaluation or referral for bariatric surgery is provided with the request ; **AND**
- The recipient has established cardiovascular disease based on **at least ONE** of the following that is **stated on the request**:
  - Prior myocardial infarction, and **ALL** of the following are **stated on the request**:
    - The recipient's current risk stratification of yearly risk for CV death or MI; **AND**
    - The recipient:
      - is currently on high-intensity statin therapy; **OR**
      - has a medical reason for not using high-intensity statin therapy and is currently on moderate intensity statin therapy; **AND**
    - If the recipient's risk stratification indicates very high risk, the recipient is currently taking ezetimibe or has a medical reason for not using ezetimibe; **AND**
    - The recipient's current blood pressure is:
      - <130/<80; **OR**
      - ≥130/≥80 **AND** the recipient is currently taking **TWO or more** of the following: ACE-I, ARB, beta-blocker; **AND**
    - The recipient is currently taking aspirin or has a medical reason for not using aspirin; **OR**
  - Prior stroke (ischemic or hemorrhagic stroke), and **ALL** of the following are **stated on the request**:
    - The recipient's current blood pressure is
      - <130/<80; **OR**
      - ≥130/≥80 and the recipient is currently taking **TWO or more** of the following: diuretic, ACE-I or ARB; **AND**
    - If the recipient's LDL >100 mg/dL, the recipient:
      - is currently on high-intensity statin therapy; **OR**

        - has a medical reason for not using high intensity statin and is currently on moderate intensity statin therapy; **AND**
    - The recipient:
        - is currently on antiplatelet therapy (e.g., aspirin, clopidogrel); **OR**
        - has a medical reason for not using antiplatelet therapy; **AND**
    - If the recipient has comorbid atrial fibrillation, the recipient:
        - is currently on anticoagulation therapy (e.g., warfarin or direct acting oral anticoagulant [DOAC]); **OR**
        - has a medical reason for not using anticoagulation; **OR**
- Symptomatic peripheral arterial disease, and **ALL** of the following are **stated on the request**:
    - The recipient has PAD as evidenced by one of the following, which is **stated on the request**:
        - Intermittent claudication with ankle-brachial index (ABI) less than 0.85 (at rest); **OR**
        - History of peripheral arterial revascularization procedure; **OR**
        - Amputation due to atherosclerotic disease; **AND**
    - The recipient is currently on statin therapy; **AND**
    - The recipient's current blood pressure is:
        - <130/<80; **OR**
        - ≥130/≥80 and the recipient is currently taking **TWO or more** antihypertensives with differing mechanisms of action; **AND**
    - The recipient is:
        - currently on antiplatelet therapy (e.g., aspirin, clopidogrel); **OR**
        - has a medical reason for not using antiplatelet therapy; **AND**
- The recipient does not have type 1 or type 2 diabetes; **AND**
- The recipient will not use this medication with other semaglutide products or with any other GLP-1 receptor agonists; **AND**
- The prescriber **states on the request** that semaglutide treatment will be used as adjunct treatment to standard of care therapy, which includes, but is not limited to:
    - Optimized pharmacotherapy for established cardiovascular disease; **AND**
    - Individualized healthy lifestyle counseling; **AND**
    - Behavioral modification including a reduced calorie diet and increased physical activity.

Duration of approval for initiation of therapy: 6 months

Approval Criteria for Continuation of Therapy

- **ONE** of the following is true:
    - The recipient is currently receiving this medication, as evidenced by paid pharmacy claims; **OR**
    - Documentation provided with the request indicates that the recipient met the initial approval criteria and has received this medication for at least 30 days; **AND**
- **ONE** of the following is true and is **stated on the request**:
    - The recipient lost ≥ 5 percent of baseline body weight **OR** has continued to maintain their initial 5 percent weight loss (Documentation of the recipient's baseline weight prior to initiation of therapy and the recipient's current weight, including the date the weights were taken must be submitted); **OR**

    - The recipient **DID NOT** reach or maintain the weight loss goal of at least 5 percent and clinical justification for continuation of current therapy is provided; **AND**
- The prescriber **states on the request** that semaglutide treatment will be used as adjunct treatment to standard of care therapy, which includes, but is not limited to:
    - Optimized pharmacotherapy for established cardiovascular disease; **AND**
    - Individualized healthy lifestyle counseling; **AND**
    - Behavioral modification including a reduced calorie diet and increased physical activity.

Duration of approval for continuation / maintenance of therapy: 3-6 months

- **For weight loss ≥ 5%, approve for an additional 6 months.**
- **For weight loss < 5%, approve for 3 months if clinical justification is provided as to why this weight loss goal was not reached.**

If previous duration of approval was for 3 months:

- **For weight loss ≥ 5%, approve for an additional 6 months.**
- **For weight loss < 5%, do not approve.**

Metabolic Dysfunction-Associated Steatohepatitis (MASH) (Wegovy Injection Only)

This indication is approved under accelerated approval based on improvement of MASH and fibrosis. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

Approval Criteria for Initiation of Therapy

- The request is for the injectable dosage form; **AND**
- The recipient is 18 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of metabolic dysfunction-associated steatohepatitis (MASH) confirmed by **ONE** of the following**:** (must be **stated on the request**)
    - Liver biopsy performed within the 6 months prior to initiation of treatment showing a NAFLD Activity Score (NAS) ≥ 4 with a score of at least 1 in each of the following NAS components:
        - Steatosis; **AND**
        - Ballooning; **AND**
        - Lobular inflammation; **OR**
    - **ONE** of the following imaging exams performed within the 3 months prior to initiation of treatment:
        - Elastography; **OR**
        - Computed tomography; **OR**
        - Magnetic resonance imaging based techniques (e.g. MRE, MRI-PDFF); **AND**
- The prescriber **states on the request** that the recipient has stage F2 or F3 fibrosis; **AND**
- The prescriber **states on the request** that the recipient does not have evidence of decompensated cirrhosis; **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a gastroenterologist or hepatologist; **AND**

- The prescriber **states on the request** that the requested medication will be used as adjunct treatment to standard of care therapy, which includes, but is not limited to:
    - Optimized pharmacotherapy for established metabolic and cardiovascular conditions; **AND**
    - Behavioral modification, including a reduced calorie diet and increased physical activity.

Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy (e.g., improvement or stabilization of fibrosis); **AND**
- The prescriber **states on the request** that the recipient has not advanced to fibrosis stage 4.

Duration of approval for initiation and continuation of therapy: 12 months

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References

ClinicalTrials.gov. Semaglutide Effects on Heart Disease and Stroke in Patients With Overweight or Obesity (SELECT). https://www.clinicaltrials.gov/study/NCT03574597

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Revision / Date	Implementation Date
Policy created / April 2024	July 2024
Expanded requirements for CV disease, added bariatric surgery requirement / September 2024	October 2024
Added criteria for new indication of MASH, added wording for tablet formulation, removed reference to maintenance dose, updated references / November 2025	March 2026