Semaglutide (Wegovy®)
Treatment Agreement for Louisiana Medicaid Recipients

Prescriber Instructions: Please submit the completed treatment agreement with the initial clinical authorization request for semaglutide (Wegovy®).

Patient Information		**Prescriber Information**	
Recipient Name:		Prescriber Name:	
Medicaid Recipient ID #:		Medicaid Provider ID # or NPI:	
Date of Birth:		Office Contact:	
Current Weight/Date:	Current BMI/Date:	Provider Phone Number:	Provider Fax Number:

Patient Instructions: Please read this treatment agreement carefully. Please initial each item to show you have read and understand it. Be sure to ask any questions you have before you sign it. Sign and date at the bottom of the form.		**Patient's Initials**
1.	I have received advice about how to make healthier choices in my life.	
2.	I have received counseling about the importance of making changes in my lifestyle. These changes include a reduced calorie diet and increased physical activity.	
3.	I have been told how to take Wegovy®. I understand how to take it. I am aware of possible side effects.	
4.	I will take Wegovy® like my doctor said. I will not miss doses or share my medicine with anyone.	
5.	I will follow a reduced calorie diet as directed by my doctor.	
6.	I will increase my physical activity as directed by my doctor.	

I have read the above statements. I understand and will adhere to this agreement.

Patient Signature:_____ Date:_____

Physician Signature:_____ Date:_____