Reset Form Print Form

New Hampshire Medicaid Fee-for-Service (FFS) Program
Prior Authorization Drug Approval Form
MACE - Wegovy

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME: **FIRST NAME:**

MEDICAID ID NUMBER: **DATE OF BIRTH:** – –

GENDER: ☐ Male ☐ Female

Drug Name **Strength**

Dosing Directions **Length of Therapy**

SECTION II: PRESCRIBER INFORMATION

LAST NAME: **FIRST NAME:**

SPECIALTY: **NPI NUMBER:**

PHONE NUMBER: – – **FAX NUMBER:** – – –

SECTION III: CLINICAL HISTORY

1. Does the patient have a diagnosis of Type 1 or Type 2 Diabetes Mellitus? ☐ Yes ☐ No
2. Has the patient failed to lose weight on a low-calorie diet (1,200 kcal/day for women, 1,600 kcal/day for men) **and** increased physical activity including strength training? ☐ Yes ☐ No
   Explain if no: _____
3. Does the patient have a body mass index (BMI) of at least 27 kg/m^2? ☐ Yes ☐ No
4. Patient's BMI: _____ Weight: _____ Height: _____ Date: _____

Phone: 1-866-675-7755 **Fax**: 1-888-603-7696
© 2021–2026 Prime Therapeutics Management LLC, a Prime Therapeutics LLC company
Revision Date: 01/01/2026

New Hampshire Medicaid Fee-for-Service (FFS) Program
Prior Authorization Drug Approval Form
MACE - Wegovy

PATIENT LAST NAME: | | | | | | | | | | | | |

PATIENT FIRST NAME: | | | | | | | | | | | | |

SECTION III: CLINICAL HISTORY *(continued)*

5. Does the patient have established cardiovascular disease? ☐ Yes ☐ No
6. Is the patient currently taking drugs for secondary prevention of major adverse cardiovascular events (MACE)? (Check all that apply.)
   - ☐ Statin, ezetimibe, PCSK9 inhibitor, or combination_____
   - ☐ Blood pressure medication (ACEI/ARB)_____
   - ☐ Beta-blocker _____
   - ☐ Anticoagulant or Antiplatelet therapy_____
7. Is the patient at risk for MACE? ☐ Yes ☐ No
8. Is there any additional information that would help in the decision-making process? If additional space is needed, please use a separate sheet.

SECTION IV: RENEWAL

1. Has the patient continued on a low-calorie diet (1,200 kcal/day for women, 1,600 kcal/day for men) **and** increased physical activity including strength training? ☐ Yes ☐ No
2. Has the patient continued the guideline-recommended measures for MACE prevention? ☐ Yes ☐ No
   List additional medications: _____
3. Has the patient experienced any treatment-restricting adverse effects? ☐ Yes ☐ No

Baseline body weight: _____ **Renewal body weight:** _____

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____