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State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

M E M O R A N D U M

DATE: June 25, 2024

TO: All Louisiana Medicaid Prescribing Providers and Pharmacists

FROM: Kimberly Sullivan, Medicaid Executive Director KLS

SUBJECT: Louisiana Medicaid Pharmacy Clinical Authorization for Semaglutide (Wegovy®) - July 2024

Effective July 1, 2024, the Louisiana Medicaid Fee for Service (FFS) Pharmacy Program and Managed Care Organizations (MCOs), in consultation with the Drug Utilization Review (DUR) Board, will implement clinical authorization for semaglutide (Wegovy®) for recipients with select cardiovascular indications and other approval criteria. The clinical authorization applies to pharmacy claims submitted to Gainwell for FFS and to Magellan for MCOs (Aetna, AmeriHealth Caritas, Healthy Blue, Humana Healthy Horizons, Louisiana Healthcare Connections, and UnitedHealthcare).

Clinical Authorization for Semaglutide (Wegovy®)

Pharmacy claims for semaglutide (Wegovy®) require an approved clinical authorization for reimbursement. The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for semaglutide (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.

Pharmacy claims submitted without an approved clinical authorization will deny at Point of Sale (POS) with:

Denial from Gainwell (FFS Only): **NCPDP rejection code 88** (DUR Reject Error) mapped to **EOB code 066** (Clinical Authorization Required).

FFS override provisions should be addressed through the Clinical Authorization process.

Denial from Magellan (MCO Only): **NCPDP rejection code 75** (Prior Authorization Required) with additional message: Clinical Authorization required. Please call 1-800-424-1664.

Additional Information:
Refer to http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf for the PDL, which is inclusive of the *Louisiana Uniform Prescription Drug Prior Authorization Form*, medication list, criteria, and diagnosis code list.

If you have questions about the content of this memo, you may contact the FFS pharmacy help desk by phone at (800) 437-9101.

FFS pharmacy claims should be submitted to Gainwell Technologies. MCO pharmacy claims should be submitted to Magellan.

If you have questions about pharmacy claims billing, you may contact the appropriate plan at their pharmacy help desk listed in the chart below.

Healthcare Provider	Pharmacy Help Desk	Pharmacy Help Desk Phone Number
Aetna, AmeriHealth Caritas, Healthy Blue, Humana Healthy Horizons, Louisiana Healthcare Connections, UnitedHealthcare	Magellan	(800) 424-1664
Fee for Service	Gainwell Technologies	(800) 648-0790

Please forward this notice to other providers to assist with notification. Your continued cooperation and support of the Louisiana Medicaid Program efforts to coordinate care and improve health are greatly appreciated.

KS/MBW/GJS

c: Healthy Louisiana Plans
Melwyn B. Wendt
Gainwell Technologies
Magellan

Enclosures

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 Initiation of Therapy

- The recipient is 45 years of age or older on the date of the request; **AND**
- The recipient has a documented Body Mass Index (BMI) of 27 kg/m^2 or greater (**date and results of the most recent BMI calculation are stated on 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; **OR**
    - Prior stroke (ischemic or hemorrhagic stroke); **OR**
    - Peripheral arterial disease, 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 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; **AND**
- The request is for a maintenance dose of 1.7mg or 2.4mg once weekly (if appropriate based on recipient's current titration schedule).

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.**

Note: If the recipient is unable to tolerate a 1.7mg weekly maintenance dose, the medication should be discontinued.

References

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

Jensen MD, et al. 2013 AHA/ACC/TOS guideline for the management of overweight and obesity in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society. Circulation. 2013; 129:S102–S138

Wegovy (semaglutide) [package insert]. Plainsboro, NJ: Novo Nordisk Inc.; March 2024. https://www.novo-pi.com/wegovy.pdf

Revision / Date	Implementation Date
Policy created / April 2024	July 2024

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:_____