Print Reset

United Healthcare Community Plan

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

GLP-1 RECEPTOR AGONISTS FOR CARDIOVASCULAR RISK REDUCTION

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

For initial requests, continue below. For renewal requests, proceed to Length of Authorization. If approved, initial authorizations are granted for 6 months. Renewal authorizations are granted for 12 months.

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

- **FDA indicated medications only**
- **Must be prescribed by a cardiologist or vascular specialist for the member to receive authorization**

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

- ☐ The member is 45 years of age or older; **AND**
- ☐ The medication is prescribed by a cardiologist or vascular specialist; **AND**
- ☐ The member has a clinical history of one of the following:
  - ☐ Myocardial infarction (MI), defined as cardiac biomarkers, an electrocardiogram, or cardiac imaging; **OR**
  - ☐ Stroke, defined as neurological dysfunction as a result of a hemorrhage or infarction; **OR**
  - ☐ Peripheral artery disease, as defined by intermittent claudication with ankle-brachial index less than 0.85 at rest, or peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease; **AND**
- ☐ The member has not had a MI, stroke, transient ischemic attack, or hospitalization for unstable angina in the last 60 days; **AND**
- ☐ The member has a BMI ≥ 27 kg/m^2; **AND**
- ☐ The provider attests that the member received individualized healthy lifestyle counseling; **AND**
- ☐ The member does not have a previous diagnosis of diabetes; **AND**
- ☐ The member does not have pancreatitis, acute suicidal behavior/ideation, personal or family history of medullary thyroid cancer or multiple endocrine neoplasia 2 syndrome

(Form cntinued on next page.)

Member's Last Name: **Member's First Name:**

LENGTH OF AUTHORIZATION

Renewal requests (see additional requirements below):

☐ The member continues to meet the criteria

☐ The member is being treated with a maintenance dosage of the requested drug

☐ **Attachments**

Prescriber Signature (Required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328
Pharmacy PA call center: 1-800-310-6826