State of Maine Department of Health &Human Services
MaineCare/MEDEL Prior Authorization Form

SEMAGLUTIDE/MACE REDUCTION

Phone: 1-888-445-0497 **ONE Drug Per Form ONLY – Use Black or Blue Ink** Fax: 1-888-879-6938

Member ID #: |__|__|__|__|__|__|__|__|__|__| Patient Name: ______________________ DOB: ____________
(NOT MEDICARE NUMBER)

Patient Address:____

Provider DEA: |__|__|__|__|__|__|__|__|__|__| Provider NPI: __|__|__|__|__|__|__|__|__|__|

Provider Name:______________________________________ Phone:______________

Provider Address:____________________________________ Fax:______________

Pharmacy Name:__________________Rx Address:____________________Rx phone:____________

Provider must fill all information above. It must be legible, correct and complete or form will be returned.

(Pharmacy use only): NPI: __|__|__|__|__|__|__|__|__|__| NABP: |__|__|__|__|__|__|__| NDC: |__|__|__|__|__|__|__|__|__|__|__|

Initial Approvals limited to 3 months.

Drug Name	Strength	Dosage Instructions	Quantity	Days Supply (34 retail / 90 mail order)	Refills
______________	________	________	________	__________	1 2 3 4 5

Medical Necessity Documentation Required: (Attach copies of supporting office notes.)

Is this medication being used for weight loss only? ❑ Yes ❑ No
(MaineCare policy does not allow coverage for weight loss products)

Is the patient an adult with BMI > 27kg/m ❑ Yes ❑ No

Does the patient have:

- At least one of the following comorbidities*: history of stroke, MI, or symptomatic PAD ❑ Yes ❑ No
  **Require documentation through submission of chart notes*
- End stage renal disease or dialysis ❑ Yes ❑ No

Have you obtained current A1C level? ❑ Yes ❑ No

- Is patient diabetic? ❑ Yes ❑ No
  If yes, please list medication the patient has tried: ______________________________
  ____

Does the patient have NYHA class IV heart failure? ❑ Yes ❑ No

Is the patient concurrently taking a lipid-lowering agent? ❑ Yes ❑ No

Certification to seek exception from chart documentation requirement:
I certify that (a) the information provided is accurate and complete to the best of my knowledge, and (b) that any required supporting medical record documentation is physically or electronically accessible and satisfies the explicitly posted relevant PDL criteria. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. As per MaineCare Benefits Manual, Chapter I, Sections 1.16 and 1.19, "sanctions" (including recouping payments previously made) "may be imposed by the Department against a provider submitting false information for the purpose of meeting prior authorization requirements."

Provider Signature: ______________________ Date of Submission: ______________________
***MUST MATCH PROVIDER LISTED ABOVE**

OR

Pursuant to the MaineCare Benefits Manual, Chapter I, Section 1.16, The Department regards adequate clinical records as essential for the delivery of quality care, such comprehensive records are key documents for post payment review. Your authorization certifies that the above request is medically necessary, meets the MaineCare criteria for prior authorization, does not exceed the medical needs of the member and is supported in your medical records.

Provider Signature: ______________________ Date of Submission: ______________________
***MUST MATCH PROVIDER LISTED ABOVE**