To:	**Jai Medical Providers**
From:	**MC-Rx**
Date:	**December 26, 2025**
Subject:	**Formulary Update – Wegovy Criteria and Opioid PA Form Updates**

Effective immediately, the following updates have been made:

- Maryland Medicaid has updated the ***Unified OPIOID PRIOR AUTHORIZATION FORM*** for pharmacy prior authorization requests for opioid medications for the HealthChoice Program, including MCOs. Please begin using this new form; any requests received on the old form after April 1, 2026 will be returned to the requestor. A copy of this form has been attached to this notice and is available on our pharmacy page at https://www.jaimedicalsystems.com/providers/pharmacy/. Non-exempt opioid prior authorizations continue to need renewal every 6 months.

- Maryland Medicaid has updated their PA criteria for Wegovy. Jai Medical Systems follows Maryland Medicaid criteria for this medication, and the updated criteria is below. The changes that were made to the PA criteria for Wegovy include:
  - Type 1 and Type 2 diabetics are no longer excluded from approval criteria for Wegovy
  - Criteria for the new MASH indication have been added
  - Criteria for the MACE indication were updated to include that a cardiologist needs to be either the prescriber or requestor for Wegovy or documentation needs to be included that a cardiologist was consulted and agreed that Wegovy was appropriate to use for the reduction of MACE.
  - The renewal criteria require that the initial approval criteria continue to be met.
  - The initial approval for Wegovy will now be 4 months and subsequent renewals will be for periods of 6 months.

  Other details of note include:
  - Other uses for weight loss remain excluded from coverage under the HealthChoice Program and Jai Medical Systems benefit.
  - Specialist involvement, at least as a consultant, is needed for all Wegovy or Zepbound requests (see criteria for required specialty information).
  - There is a list of acceptable tests that can be used as part to demonstrate the member's Fibrosis for the MASH indication. Other tests cannot be accepted, though the requestor may use other lab results to calculate a FNI or MACK-3 score.
  - To continue to meet initial approval criteria for renewals, ensure that visit notes and labs (if applicable) are up to date with renewal requests.

Medication	(WEGOVY 0.25 MG/0.5ML, 0.5MG/0.5ML, 1 MG/0.5ML, 1.7 MG/0.75ML, 2.4 MG/0.75ML)

Covered Uses	Only the following FDA approved indications (other uses remain excluded with other weight loss medications): ○ To reduce the risk of (MACE) Major Adverse Cardiovascular Events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke), in combination with a reduced calorie diet and increased physical activity, for adults with established cardiovascular disease (ASCVD) who are either obese or overweight ○ Treatment of non-cirrhotic metabolic dysfunction-associated steatohepatitis (MASH), formerly known as nonalcoholic steatohepatitis (NASH), with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) in adults
Exclusion Criteria	(a) Use for weight loss NOT in conjunction with one of the covered uses listed above; or (b) Co-administration with any other GLP-1 receptor agonist products. (c) Use that is not in accordance with prescribing information (d) Any other indication-specific exclusions as described in the Required Medical Information below
Required Medical Information	For Initial Approval: Wegovy will be considered for coverage when <u>all</u> of the criteria below are met, confirmed with supporting medical documentation. **Criteria for MACE:** (a) Member age is 18 years or older; AND (b) Prescribed by or in consultation with a cardiologist; AND (c) Member is overweight/obese with a recent BMI (based on accurate height and weight within the past 90 days) greater than or equal to 27kg/m2; AND (d) Member has established and documented atherosclerotic cardiovascular disease (ASCVD) as evidenced by one or more of the following: 1. Prior myocardial infarction; AND/OR 2. Prior stroke (ischemic or hemorrhagic stroke); AND/OR 3. Symptomatic peripheral arterial disease (PAD) as evidenced by: a. Intermittent claudication with ankle-brachial index (ABI) less than 0.85 (at rest); OR b. Peripheral arterial revascularization procedure; OR c. Amputation due to atherosclerotic disease; AND (e) Prescriber attests that medication is prescribed in accordance with prescribing information, including screening for any black box warnings and all contraindications. **Criteria for non-cirrhotic MASH:** (a) Member age is 18 years or older; AND (b) Prescribed by or in consultation with a gastroenterologist or hepatologist; AND (c) The member has noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH), with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis): ○ Diagnosis of noncirrhotic MASH with liver fibrosis stage F2 or F3, confirmed by liver biopsy or one of the noninvasive testing methods in the list below, from within the past 180 days; AND

<table>
<tr><td></td><td>(d) Absence of concurrent use of another medication(s) indicated for noncirrhotic MASH; AND
(e) Prescriber attests that medication is prescribed in accordance with prescribing information, including screening for any black box warnings and all contraindications; AND
(f) Patients will be excluded from treatment when:
1. There are documented causes of chronic liver disease other than non-alcoholic fatty liver disease (NAFLD)
2. Presence of liver cirrhosis or a history of decompensated liver diseases
3. History of liver transplantation or current/prior hepatocellular carcinoma
4. Excessive alcohol consumption (20 gm per day for female; 30 gm per day for male)</td></tr>
<tr><td>Age Restriction</td><td>Age 18 or older</td></tr>
<tr><td>Max Quantity Per Month</td><td>Four (4) pens/28 days, any strength</td></tr>
<tr><td>Coverage Duration</td><td>4 months for initial approval and 6 months for subsequent renewals</td></tr>
<tr><td>Accepted Fibrosis Testing</td><td>Noninvasive methods for the determination of fibrosis in MASLD
Numerous noninvasive methodologies have been developed to determine the degree of fibrosis in patients with Metabolic dysfunction-associated steatotic liver disease (MASLD). These methodologies employ either the use of biomarkers or the evaluation of liver stiffness to make a determination regarding the degree of liver fibrosis. Below is a list of acceptable noninvasive testing (as identified by Maryland Medicaid) to determine if a patient meets the criteria for approval of Wegovy for this indication. Wegovy is labeled for the treatment of patients with metabolic dysfunction-associated steatohepatitis (MASH) who have a fibrosis score of F2-F3.
<table>
<tr><th>Noninvasive test</th><th>CPT Code</th><th>Score comparable to F2-F3 fibrosis</th></tr>
<tr><td colspan="3">Imaging-Based Fibrosis Tests</td></tr>
<tr><td>Transient elastography</td><td>91200</td><td>8 kPa to 15 kPa</td></tr>
<tr><td>Shear wave elastography (pSWE)</td><td>76981</td><td>1.2 m/s to 2 m/s</td></tr>
<tr><td>Magnetic resonance elastography (MRE)</td><td>76391</td><td>3.4 kPa to 6.7 kPa</td></tr>
<tr><td colspan="3">Blood-Based Fibrosis Tests</td></tr>
<tr><td>ELF</td><td>81517</td><td>7.7 to 9.8</td></tr>
<tr><td>Fibrotest</td><td>81596</td><td>0.32 to 0.48</td></tr>
<tr><td>Fibrotic NASH Index (FNI)*</td><td>N/A</td><td>0.10 to 0.33</td></tr>
<tr><td>MACK-3*</td><td>N/A</td><td>0.135 to 0.549</td></tr>
</table>
* CPT code is not available, but FNI or MACK-3 score may be submitted to fulfill the diagnostic requirement for the clinical criteria.</td></tr>
<tr><td>Renewal Criteria</td><td>All criteria in the initial approval must continue to be met.</td></tr>
<tr><td>Criteria Updates</td><td>Criteria for Wegovy will be updated to align with the criteria from Maryland Medicaid as further updates are reported.</td></tr>
</table>

All changes in this notice supersede any earlier edits to the formulary.

Providers can contact MC-Rx's Prior-Authorization Department at 800-555-8513 for assistance with PA requests or questions regarding clinical guidelines. Our PA Department is available Monday through Friday from 8:30 am-5:30 pm EST. For assistance with PA requests during non-business hours please contact our 24-hour customer service department at 800-213-5640.

OPIOID PRIOR AUTHORIZATION FORM

Incomplete forms will not be reviewed

Managed care organizations (listed) and Medicaid fee-for-service use this form for opioid prior authorization.

Fax completed forms to the number corresponding to the patient's plan.

MCO and Fee-for-Service	Telephone	Fax
Aetna Better Health of Maryland	1-866-827-2710	1-866-270-3298 or www.aetnabetterhealth.com/maryland
CareFirst Blue Cross Blue Shield Community Health Plan of Maryland	1-800-730-8530	1-866-249-6155 OR CVS Caremark Prior Authorization Forms | CoverMyMeds
Jai Medical Systems	1-800-555-8513	1-866-999-7736 OR 1-800-583-6010
Kaiser Permanente Health Choice	310-816-2424	703-466-4802
Maryland Medicaid Fee-for-Service	(800) 932-3918	(866) 440-9345
Maryland Physicians Care	1-800-953-8854	410-372-4228
MedStar Family Choice	1-800-905-1722	410-933-2274 or 410-350-7492
Priority Partners	1-800-654-9728	1-866-212-4756
United Healthcare Community Plan	1-800-318-8821 OR 1-844-445-5264	1-844-881-6010
WellPoint Maryland	1-833-707-0868	1-844-490-4871

For Amerigroup and UnitedHealthcare forms visit:
https://health.maryland.gov/mmcp/pap/Pages/Pharmacy-Program-Forms.aspx

All prescribers must complete SECTION 1, SECTION 2, AND SECTION 3.

Prescribers must complete either SECTION 4 or SECTION 5 as appropriate.

TO AVOID DELAYS in processing this request, please ensure that contact information is accurate in case additional information is required.

Duration of prior authorization is determined by Medicaid fee-for-service of managed care organizations.

For additional information about individual managed care organizations' opioid-prescribing requirements, visit:
https://health.maryland.gov/mmcp/pap/Pages/Pharmacy-Program-Forms.aspx

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OPIOID PRIOR AUTHORIZATION FORM

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SECTION 1: DEMOGRAPHICS	
Date: (MM/DD/YYYY)	
Patient Name:	
MCO Plan ID#:	
MD Medicaid ID#:	
Date of Birth: (MM/DD/YYYY)	Gender as listed by the patient: ☐ Male ☐ Female
Name of MCO:	Other Insurance? :
Prescriber Name:	Prescriber NPI#:
Prescriber DEA#:	Phone for Prescriber:
Office Contact Name / Fax Attention to:	
Office Contact Direct Phone#:	Office / Prescriber Fax #:
Facility / Clinic Name (if applicable):	

SECTION 2: CHECK ALL THE BOXES THAT APPLY

☐ Non-Urgent Review

☐ Urgent Review: By checking this box, I certify that applying non-urgent review timeframe may lead to patient harm.

☐ Yes	☐ No	This patient is currently an inpatient at an acute care hospital.
☐ Yes	☐ No	Is this patient being discharged from the hospital or ED?
☐ Yes	☐ No	Is the patient pregnant? *(See references below.)*

1. http://www.medscape.com/viewarticle/867512
2. https://www.cdc.gov/mmwr/volumes/65/wr/mm6531a2.htm
3. https://www.fda.gov/Drugs/DrugSafety/ucm549679.htm
4. https://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm118113.htm

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SECTION 3: USE A SEPARATE FORM FOR EACH MEDICATION BEING REQUESTED

Select One: ☐ New Prescription ☐ Refill (i.e., patient has been taking medication)

Diagnosis:

Select All That Apply:

☐ Immediate-Release Opioid ☐ Extended-Release Opioid ☐ Fentanyl ☐ Methadone (for pain)

☐ Exceeds 90 MME/day ☐ Exceeds Tablet Quantity Limit (Maximum Daily Limit)

If 90 MME/day or Quantity Limit is exceeded, provide rationale:

☐ Non-Formulary / ☐ Non-Preferred: If selected, complete information within table below.

Previous Formulary Trial(s)

Drug Name/Strength/Dose	Date(s) & Duration of Trial	Treatment Outcome

Requested Drug Name: Strength:

Quantity : Length of Treatment: Day(s) Month(s)

SIG:

SECTION 4: FOR EXEMPT PATIENTS ONLY

☐ Yes	☐ No	Active Cancer Treatment	Cancer Type:
☐ Yes	☐ No	Sickle Cell Disease	
☐ Yes	☐ No	Hospice Care	Diagnosis:
☐ Yes	☐ No	Palliative Care [Diagnosis Code (Z51.5)]	Diagnosis:
☐ Yes	☐ No	Long-Term Care / Skilled Nursing Facility	

Important: The remainder of this PA form does not need to be completed for patients who meet at least one of the above exceptions in SECTION 4.

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OPIOID PRIOR AUTHORIZATION FORM

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SECTION 5: ATTESTATION REQUIRED OF ALL PRESCRIBERS FOR NON-EXEMPT PATIENTS

Choose the section (A or B) that applies.

A. For Outpatient Prescribers providing ongoing care: *EACH Question Must be Answered*

☐ Yes	☐ No	Prescriber has reviewed Controlled Substance Prescriptions in PDMP (CRISP).
☐ Yes	☐ No	Patient has/will have random Urine Drug Screens (UDS).
☐ Yes	☐ No	Naloxone prescription was provided or offered to patient/patient's household.
☐ Yes	☐ No	Patient-Prescriber Pain Management/Opioid Treatment Agreement signed and in medical record.

B. For Inpatient Hospital (Hospital), Ambulatory Surgery Center (ASC), and Emergency Room (ER) Prescribers: *EACH Question Must be Answered*

☐ Yes	☐ No	Prescriber has reviewed Controlled Substance Prescriptions in PDMP (CRISP).
☐ Yes	☐ No	Naloxone prescription was provided or offered to patient/patient's household.
☐ Yes	☐ No	I have discussed the risks/benefits associated with opioid use with patient/patient's household.
☐ Yes	☐ No	The patient is exempt from need for a Patient-Prescriber Pain Management/Opioid Treatment Agreement and random UDS, because he/she is being discharged from the Hospital/ASC/ER and opioid treatment prescribed by the discharging provider will be for less than 30 days or the need for further opioid use will be re-evaluated by an Outpatient provider within 30 days.

I certify that the benefits of opioid treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.

Prescriber Signature:_____ Date: (MM/DD/YYYY)_____

Important: Incomplete attestations will not be able to be processed by Medicaid Fee-For-Service (FFS) or Managed Care Organization (MCO) and will delay requests.