Prescriber Criteria Form Ozempic 2026 PA Fax 6080-A v3 010126.docx Ozempic (semaglutide) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Ozempic (semaglutide).

Drug Name: Ozempic (semaglutide)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed to reduce the risk of major adverse cardiovascular (CV) events in an adult patient with type 2 diabetes mellitus and established cardiovascular disease? [If yes, then no further questions.]	Yes	No
2	Is the requested drug being prescribed to reduce the risk of estimated glomerular filtration rate (eGFR) decline, end-stage kidney disease, and cardiovascular death in an adult with type 2 diabetes mellitus and established chronic kidney disease? [If yes, then no further questions.]	Yes	No
3	Is the requested drug being prescribed to improve glycemic control in an adult patient with type 2 diabetes mellitus? [Note: Ozempic is FDA-labeled for type 2 diabetes mellitus and is not indicated for prediabetes.]	Yes	No

Comments:	

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ Date:_____