YouthCare
HealthChoice Illinois

Clinical Policy: Semaglutide (Wegovy)

Reference Number: IL.PMN.295
Effective Date: 06.01.24
Last Review Date: 10.01.26
Line of Business: YouthCare HealthChoice Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Semaglutide (Wegovy®) is a glucagon-like peptide-1 (GLP-1) receptor agonist.

FDA Approved Indication(s)

Wegovy is indicated in combination with a reduced-calorie diet and increased physical activity:

- To reduce the risk of major cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established cardiovascular disease (CVD) and either obesity or overweight.
- To reduce excess body weight and maintain weight reduction long term in:
  - Adult and pediatric patients aged 12 years and older with obesity;
  - Adults with overweight in the presence of at least one weight-related comorbid condition.
- For the treatment of noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH), formerly known alcoholic steatohepatitis (NASH), with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) in adults.

Limitation(s) of use: Coadministration with other semaglutide-containing products or with any other GLP-1 receptor agonist is not recommended.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Wegovy is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Cardiovascular Event Prevention (must meet all)**:**

1. Member has at least one of the following established CVD (a, b, or c):
   a. History of myocardial infarction;
   b. History of stroke;
   c. Symptomatic peripheral arterial disease (PAD) (*see Appendix D*);
2. Age ≥ 18 years;
3. BMI ≥ 27 kg/m^2;
4. Prescriber attestation that member is currently receiving cardiovascular standard of care management (*see Appendix D)*;
5. For members with concurrent type 2 diabetes mellitus, both of the following (a and b):

   a. Failure of ≥ 3 consecutive months of Trulicity®, and liraglutide or Victoza®, unless clinically significant adverse effects are experienced or all are contraindicated;*
      **Prior authorization may be required*
   b. If member is currently receiving a GLP-1 receptor agonist and is requesting to switch to Wegovy therapy, medical justification* supports necessity for Wegovy;
      **Intolerance due to common adverse effects of the GLP-1 receptor agonists class such as gastrointestinal symptoms is not considered acceptable medical justification*
6. Wegovy is not prescribed concurrently with other semaglutide-containing products or any other GLP-1 receptor agonist(s);
7. Documentation supports member's participation in a physician-directed weight loss program that involves a reduced calorie diet, increased physical activity, and behavioral modification that meets both of the following (a and b):
   a. Been actively enrolled in a physician-directed weight loss program for at least 6 months;
   b. Will continue to be enrolled in a physician-directed weight loss program while concomitantly prescribed Wegovy;
8. Documentation of member's baseline body weight in kg;
9. Dose does not exceed the following (a or b):
   a. Injection
      i. Week 1 through 4: 0.25 mg once weekly;
      ii. Week 5 through 8: 0.5 mg once weekly;
      iii. Week 9 through 12: 1 mg once weekly;
      iv. Week 13 through 16: 1.7 mg once weekly;
      v. Week 17 and onward: 2.4 mg once weekly.
   b. Oral
      i. Week 1 through 4: 1.5 mg once daily;
      ii. Week 5 through 8: 4 mg once daily;
      iii. Week 9 through 12: 9 mg once daily;
      iv. Week 13 and onward: 25 mg once daily.

Approval duration: 6 months

B. Weight Management

1. Use of Wegovy for the treatment of weight management is a benefit exclusion and will not be authorized.

Approval duration: Not applicable

C. Metabolic Dysfunction-Associated Steatohepatitis (must meet all)**:**

1. Diagnosis of MASH (formerly known as NASH);
2. Prescribed by or in consultation with a hepatologist or gastroenterologist;
3. Age ≥ 18 years;
4. MASH with stage F2 or F3 fibrosis is confirmed by one of the following (a or b):
   a. Liver biopsy within the last 3 years;
   b. Both of the following assessments within the last 6 months (i and ii; *see Appendix E for examples*):
      i. Serum-based assessment (e.g., fibrosis-4 [FIB-4], NAFLD fibrosis score [NFS], enhanced liver fibrosis test [ELF]);

ii. Imaging-based assessment (e.g., vibration-controlled transient elastography [VCTE], magnetic resonance-based elastography [MRE], magnetic resonance imaging–proton density fat fraction [MRI-PDFF]);

5. For members with concurrent T2DM, member has received optimal diabetic standard of care therapy as evidenced by a trial of ≥ 3 consecutive months each of all of the following (a, b, and c), unless clinically significant adverse effects are experienced** or all are contraindicated;*
   a. Rybelsus®;
   b. Trulicity;
   c. Victoza or liraglutide;

   ** Prior authorization may be required*

   *** Intolerance due to common adverse effects of the GLP-1 receptor agonist class such as gastrointestinal symptoms is not considered acceptable*
6. Documentation supports member's participation in a physician-directed weight loss program that involves a reduced calorie diet, increased physical activity, and behavioral modification that meets both of the following (a and b):
   a. Been actively enrolled in a physician-directed weight loss program for at least 6 months;
   b. Will continue to be enrolled in a physician-directed weight loss program while concomitantly prescribed Wegovy;
7. Prescriber attestation that member is currently receiving standard of care management for concomitant related conditions, including T2DM, dyslipidemia, and hypertension;
8. Wegovy is not prescribed concurrently with Rezdiffra™;
9. Wegovy is not prescribed concurrently with other semaglutide-containing products or any other GLP-1 receptor agonist(s);
10. Dose does not exceed the following:
    a. Week 1 through 4: 0.25 mg once weekly;
    b. Week 5 through 8: 0.5 mg once weekly;
    c. Week 9 through 12: 1 mg once weekly;
    d. Week 13 through 16: 1.7 mg once weekly;
    e. Week 17 and onward: 2.4 mg once weekly.

Approval duration: 6 months

D. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Cardiovascular Event Prevention (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy as evidenced by one of the following (a or b):
   a. If this is the first request renewal, member has lost ≥ 5% of baseline body weight;
   b. If this is a second or subsequent renewal request, member has lost weight and/or maintained weight loss on therapy;
3. Documentation of member's current body weight in kg;
4. Prescriber attestation that member is currently receiving cardiovascular standard of care management (*see Appendix D);*
5. Wegovy is not prescribed concurrently with other semaglutide-containing products or any other GLP-1 receptor agonist(s);
6. Documentation that member is actively enrolled in a physician-directed program that involves a reduced calorie diet, increased physical activity, and behavioral modification adjunct to therapy;
7. Request meets both of the following (a and b):
   a. Injection:
      i. Does not exceed 2.4 mg SC once weekly;
      ii. Member is able to tolerate a maintenance dose of ≥ 1.7 mg SC once weekly after at least 17 weeks of Wegovy therapy.
   b. Oral
      i. Does not exceed 25mg once daily

      .

Approval duration: 12 months

B. Weight Management

1. Use of Wegovy for the treatment of weight management is a benefit exclusion and will not be authorized.

Approval duration: Not applicable

C. Metabolic Dysfunction-Associated Steatohepatitis (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*

2. After at least 12 months of therapy, member is responding positively to therapy as evidenced by, including but not limited, improvement in any of the following parameters:
   a. Improvement in fibrosis ≥ 1-stage from baseline with no worsening of MASH (i.e., no worsening of hepatocellular ballooning, lobular inflammation, or steatosis);
   b. Resolution of MASH with no worsening of fibrosis;
   c. No increase in fibrosis stage and no worsening of MASH from baseline;
3. Prescriber attestation that member is currently receiving standard of care management for concomitant related conditions, including T2DM, dyslipidemia, and hypertension;
4. Documentation that member is actively enrolled in a physician-directed program that involves a reduced calorie diet, increased physical activity, and behavioral modification adjunct to therapy;
5. Wegovy is not prescribed concurrently with Rezdiffra;
6. Wegovy is not prescribed concurrently with other semaglutide-containing products or any other GLP-1 receptor agonist(s);
7. Request meets both of the following (a and b):
   a. Dose does not exceed 2.4 mg once weekly;
   b. Member is able to tolerate a maintenance dose of ≥ 1.7 mg once weekly after at least 17 weeks of Wegovy therapy.

Approval duration: 12 months

D. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: HIM.PA.154 for health insurance marketplace and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ACE: angiotensin-converting enzyme ARB: angiotensin receptor blocker

BMI: body mass index
CVD: cardiovascular disease
DPP-4: dipeptidyl peptidase 4
ELF: enhanced liver fibrosis
FDA: Food and Drug Administration
FIB-4: fibrosis-4
GLP-1: glucagon-like peptide-1
MASH: metabolic dysfunction-associated steatohepatitis
MASLD: metabolic dysfunction–associated steatotic liver disease
MRE: magnetic resonance elastography
NASH: non-alcoholic steatohepatitis
NFS: NAFLD fibrosis score
PAD: peripheral arterial disease
PCSK9: proprotein convertase subtilisin/kexin type 9
SGLT2: sodium-glucose co-transporter
T2DM: type 2 diabetes mellitus
VCTE: vibration-controlled transient elastography

Appendix B: Therapeutic Alternatives

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Ozempic® (semaglutide)	0.25 mg to 2 mg SC once weekly, increased no more frequently than every 4 weeks For patients with type 2 diabetes and chronic kidney disease, the dosage should be increased to the maintenance dose of 1 mg once weekly after at least 4 weeks on the 0.5 mg dosage	2 mg/week
Rybelsus® (semaglutide)	Formulation R1:* Initial dose: 3 mg PO QD. After 30 days on the 3 mg dose, increase to 7 mg PO QD. May increase to 14 mg PO QD if needed after at least 30 days on the 7 mg dose Formulation R2:* Initial dose: 1.5 mg PO QD. After 30 days on the 1.5 mg dose, increase to 4 mg PO QD. May increase to 9 mg PO QD if needed after at least 30 days on the 4 mg dose **Formulations R1 and R2 are not substitutable on a mg per mg basis. Use either formulation, but do not use both formulations at the same time. Patients may switch between formulations after 30 days of treatment (i.e., after the initiation phase). When switching between the formulations, initiate the other formulation the day after discontinuing the previous formulation*	Formulation R1: 14 mg/day Formulation R2: 9 mg /day
Trulicity® (dulaglutide)	0.75 mg to 1.5 mg SC once weekly May increase to 3 mg once weekly if needed after at least 4 weeks on 1.5 mg dose. May further increase to 4.5 mg once weekly if needed after at least 4 weeks on 3 mg dose.	4.5 mg/week
liraglutide (Victoza®)	Initial: 0.6 mg SC QD for 7 days Maintenance: 1.2 mg to 1.8 mg SC QD	1.8 mg/day

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): personal or family history of medullary thyroid carcinoma (MTC) or with multiple endocrine neoplasia syndrome type 2 (MEN 2), known hypersensitivity reaction to semaglutide or to any of the excipients in Wegovy
- Boxed warning(s): risk of thyroid C-cell tumors

Appendix D: General Information- Cardiovascular Event Prevention

- In the SELECT trial, symptomatic PAD was defined as intermittent claudication with ankle-brachial index (ABI) less than 0.85 (at rest), or peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease.
- Cardiovascular standard of care management:
  - Dyslipidemia management may include a statin, ezetimibe, fibrate, omega-3 fatty acids, or proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitors.
  - Hypertension management may include an angiotensin-converting enzyme (ACE) inhibitor, angiotensin receptor blocker (ARB), calcium channel blocker, or a thiazide diuretic.
  - Non-acute management of myocardial infarction may include beta-blockers, long-term dual antiplatelet therapy with aspirin and a $P2Y_{12}$ receptor blocker, statins (high-intensity), angiotensin converting enzyme inhibitors, aldosterone antagonist, and/or nitroglycerin.
  - Secondary prevention therapies for ischemic stroke may include antithrombotic therapy, antihypertensive therapy, and/or statins.
  - Secondary prevention therapies for PAD may include antiplatelet therapy, antithrombotic therapy, lipid-lowering therapy (e.g., statins), antihypertensive therapy, and/or glycemic control therapy (e.g., metformin, sulfonylurea, GLP-1 receptor agonists, sodium-glucose cotransporter-2 [SGLT2] inhibitors, etc.).

Appendix E: General Information – MASH

- In June 2023, the nomenclature describing NASH and nonalcoholic fatty liver disease (NAFLD) was changed by an international liver disease societies consensus to MASH and metabolic dysfunction-associated steatotic liver disease (MASLD), respectively.
- MASH is defined by the presence of ≥ 5% hepatic steatosis with inflammation and hepatocyte injury (hepatocyte ballooning), with or without evidence of liver fibrosis.
- Standard of care management for concomitant related conditions:
  - T2DM management may include metformin, GLP-1 receptor agonist, SGLT2 inhibitor, sulfonylurea, dipeptidyl peptidase 4 (DPP-4) inhibitors, pioglitazone, or insulin.
  - Dyslipidemia management may include a statin, ezetimibe, fibrate, omega-3 fatty acids, or proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitors.
  - Hypertension management may include an angiotensin-converting enzyme (ACE) inhibitor, angiotensin receptor blocker (ARB), calcium channel blocker, or a thiazide diuretic.
- Examples of liver assessment scores combining serum-based and imaging-based tests to help identify MASH:
  - FAST score, as measured by FibroScan and serum aspartate aminotransferase (AST);

- MAST score as measured by MRI-PDEF, MRE, and serum AST; MEFIB score, as measured by FIB-4 and MRE.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CV event prevention, MASH	SC once weekly following dose escalation schedule: • Week 1 through 4: 0.25 mg • Week 5 through 8: 0.5 mg • Week 9 through 12: 1 mg • Week 13 through 16: 1.7 mg • Week 17 and onward*: 1.7 mg or 2.4 mg Or Oral daily following dose escalations schedule: • Week 1 through 4: 1.5 mg once daily; • Week 5 through 8: 4 mg once daily; • Week 9 through 12: 9 mg once daily; • Week 13 and onward: 25 mg once daily. If patients do not tolerate a dose during dose escalation, consider delaying dose escalation for 4 weeks. For CV event prevention , the maintenance dosage in adults is either 2.4 mg (recommended) or 1.7 mg once weekly or 25mg oral once daily If patients do not tolerate a dose during dose escalation, consider delaying dose escalation for 4 weeks. If patients do not tolerate the 2.4 mg once-weekly maintenance dose, the maintenance dose may be reduced to 1.7 mg once weekly. Discontinue Wegovy if the patient cannot tolerate the 1.7 mg dose. For MASH, the maintenance dosage is 2.4 mg once daily. If patients do not tolerate 2.4 mg once weekly, the dosage can be decreased to 1.7 mg once weekly. Consider reescalation to 2.4 mg once weekly. ** 0.25 mg. 0.5 mg, and 1 mg once-weekly dosages are initiation and escalation dosages and are not approved as maintenance dosages*	2.4 mg/week

VI. Product Availability

Pre-filled, single-dose pens: 0.25 mg, 0.5 mg, 1 mg, 1.7 mg, 2.4 mg

VII. References

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Cardiovascular Event Prevention

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MASH

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disease assessment of hepatic fibrosis and steatosis. Hepatology. Published online March 15, 2024.
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16. Cusi K, Abdelmalek MF, Apovian CM, et al. Metabolic dysfunction-associated steatotic liver disease (MASLD) in people with diabetes: The need for screening and early intervention. A consensus report of the American Diabetes Association. Diabetes Care 2025;48:1057-1082.

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
C9399	Unclassified drugs or biologicals
J3490	Unclassified drugs

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created: adapted from previously approved policy CP.PHAR.295 to align with HFS PDL	5.6.24	05.24
Updated formatting	9.3.24	9.3.24
4Q 2025 Annual Review: RT4: Wegovy is now FDA approved for MASH – criteria updated per FDA labeling: revised biopsy lookback period from 6 months to 3 years per AASLD guidance; for imaging-based biomarker examples, replaced Fibroscan with VCTE as FibroScan is an example of VCTE; moved MAST, FAST, and MEFIB examples of non-invasive diagnostic tests to Appendix E; for members with concurrent T2DM, added trial of Rybelsus, Trulicity and Victoza; for diet and exercise criterion, clarified that member continues diet and exercise with concomitant Wegovy; for continued therapy, moved location of criterion regarding tolerance to maintenance dose of ≥ 1.7 mg once weekly after at least 17 weeks of Wegovy therapy; revised language from "if this is a second or subsequent renewal request" to "after at least 12 months of therapy" to determine positive response; references reviewed and updated.	12.9.25	
Added oral formulation	12.30.25	
Updated YouthCare logo. Clarified liraglutide or Victoza.	10.1.26	

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted

standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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