Clinical Policy: Semaglutide (Wegovy)

Reference Number: CP.PMN.295
Effective Date: FDA Approval Date
Last Review Date: 08.26
Line of Business: HIM/ICHRA, 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 injection and tablets are 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:
  - Adults with obesity or adults with overweight in the presence of at least one weight-related comorbid condition
  - Pediatric patients aged 12 years and older with obesity (*Wegovy injection only)*.

Wegovy injection is additionally indicated for the treatment of:

- Noncirrhotic 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. Continued approval for this indication may be contingent upon the verification and description of clinical benefit in a confirmatory trial.
- **[Pending]** Patients with obesity-related heart failure with preserved ejection fraction (HFpEF).

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 and NN9932 are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria*

**Criteria will mirror the clinical information from the prescribing information once FDA-approved*

A. Heart Failure (must meet all):

1. Request is for Wegovy injection;
2. Diagnosis of chronic HF of New York Heart Association (NYHA) Class II, III, or IV;

3. Prescribed by or in consultation with a cardiologist;
4. Age ≥ 18 years;
5. Body mass index (BMI) ≥ 30 kg/m^2;*
6. Member has a left ventricular ejection fraction (LVEF) ≥ 50%;*
7. Member is receiving stable (i.e., no changes in dose for at least the last month) optimally tolerated dosages of guideline-directed medical therapies for HFpEF that includes all of the following classes, unless clinically significant adverse effects are experienced or all are contraindicated (a and b; *see Appendix D*):**
   ** For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395*
   a. Sodium-glucose cotransporter 2 (SGLT2) inhibitor (*see Appendix B for examples)*;
   b. Secondary therapies, if applicable: loop diuretic, mineralocorticoid antagonist (MRA), and/or angiotensin receptor-neprilysin inhibitor (ARNI) or angiotensin receptor blocker (ARB) (*see Appendix B for examples)*;
8. For members with concurrent type 2 diabetes mellitus (T2DM), both of the following (a and b):**
   ** For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395*
   a. Member has received optimal diabetic standard of care therapy as evidenced by a trial of ≥ 3 consecutive months of each of the following (i, ii, and iii), unless clinically significant adverse effects are experienced or all are contraindicated:*
      i. Ozempic ® or Rybelsus®;
      ii. Trulicity ®
      iii. Liraglutide (generic Victoza ®);
      **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 agonist class such as gastrointestinal symptoms is not considered acceptable medical justification*
9. Wegovy is not prescribed concurrently with other semaglutide-containing products or any other GLP-1 receptor agonist(s);
10. Documentation support's 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;
11. Documentation of member's baseline body weight in kg;
12. 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

B. Weight Management

1. Use of Wegovy or NN9932 for the treatment of weight management is a benefit exclusion and will not be authorized.

Approval duration: Not applicable

C. 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/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace/ICHRA and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace/ICHRA 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/ICHRA and CP.PMN.53 for Medicaid.

II. Continued Therapy*

**Criteria will mirror the clinical information from the prescribing information once FDA-approved*

A. Heart Failure (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 renewal request, both of the following (i and ii):
      i. Member has lost ≥ 5% of baseline body weight;
      ii. Improvement in <u>any</u> of the following parameters: heart failure symptom frequency (e.g., fatigue, dyspnea, edema), physical limitations, and exercise function;
   b. If this is a second or subsequent renewal request, both of the following (i and ii):
      i. Member has lost weight and/or maintained weight loss on therapy;
      ii. Stabilization or improvement in <u>any</u> of the following parameters: heart failure symptom frequency (e.g., fatigue, dyspnea, edema), physical limitations, and exercise function;
3. Documentation of member's current body weight in kg;
4. Provider attestation that member is currently receiving guideline-directed medical therapies for HFpEF (*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 weight loss 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. Dose does not exceed 2.4 mg once weekly;
   b. After the initial dose escalation period (*see Section V),* maintenance dose is ≥ 1.7 mg once weekly.

Approval duration: 12 months

B. Weight Management

1. Use of Wegovy or NN9932 for the treatment of weight management is a benefit exclusion and will not be authorized.

Approval duration: Not applicable

C. 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/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace/ICHRA and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace/ICHRA 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/ICHRA 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 – HIM.PA.154 for health insurance marketplace/ICHRA and 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
ARNi: angiotensin receptor-naprilysin inhibitors
BMI: body mass index
DPP-4: dipeptidyl peptidase 4
ELF: enhanced liver fibrosis
FDA: Food and Drug Administration

FIB-4: fibrosis-4
GLP-1: glucagon-like peptide-1
GDMT: guideline-directed medical therapy
HF: heart failure
HFpEF: heart failure with preserved ejection fraction
MASH: metabolic dysfunction-associated steatohepatitis
MASLD: metabolic dysfunction–associated steatotic liver disease
MRA: mineralocorticoid antagonists
MRE: magnetic resonance elastography
NASH: non-alcoholic steatohepatitis
NFS: NAFLD fibrosis score
NYHA: New York Heart Association
PCSK9: proprotein convertase subtilisin/kexin type 9
SGLT2: sodium-glucose co-transporter
T2DM: type 2 diabetes mellitus

Appendix B: Therapeutic Alternatives

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Ozempic® (semaglutide)*	Injection: • 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 Tablet: 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	Injection: 2 mg/week Tablet: 9 mg/day
Rybelsus® (semaglutide)*	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	14 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
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
ARNI: sacubitril/valsartan (Entresto®)	24/26 to 49/51 mg PO BID	97/103 mg BID
ARBs: candesartan, losartan, valsartan	Varies	Varies
MRAs: eplerenone, spironolactone	Varies	Varies
SGLT2 inhibitors: dapagliflozin (Farxiga®), Jardiance® (empagliflozin), Inpefa® (sotagliflozin)	Varies	Varies
Loop diuretics: furosemide (Lasix®), bumetanide (Bumex®), torsemide	Varies	Varies

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

- Heart failure
  - The 2023 American College of Cardiology expert consensus states that all individuals with a diagnosis of HFpEF should be treated with an SGLT2 inhibitor, with the goal of reducing cardiovascular death/heart failure hospitalization and improving health status. In those with an LVEF < 55% to 60, use of an MRA, ARNI, or ARB (when an ARNI is not feasible based on the strength and more contemporary evidence of ARNI vs ARB as described in the guidelines). Loop diuretic agents should be used for individuals with fluid retention to reduce congestion and improve symptoms.

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Semaglutide (Wegovy) injection	HFpEF*	SC once weekly following dose escalation schedule:* • Week 1 through 4: 0.25 mg	2.4 mg/week*

Drug Name	Indication	Dosing Regimen	Maximum Dose
		• 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 If patients do not tolerate a dose during dose escalation, consider delaying dose escalation for 4 weeks. The maintenance dosage in adults is either 2.4 mg (recommended) or 1.7 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*	

VI. Product Availability

- Prefilled, single-dose pens: 0.25 mg, 0.5 mg, 1 mg, 1.7 mg, 2.4 mg, Wegovy HD 7.2 mg
- Prefilled, single-dose syringe: 0.25 mg, 0.5 mg, 1 mg, 1.7 mg, 2.4 mg
- Tablets: 1.5 mg, 4 mg, 9 mg, 25 mg

VII. References

1. Wegovy Prescribing Information. Plainsboro, NJ: Novo Nordisk Inc.; May 2026. Available at: www.wegovy.com. Accessed May 19, 2026.
   Heart Failure
2. Kosibord MN, Abildstrom SZ, Borlaug BA, et al. Semaglutide in patients with heart failure with preserved ejection fraction and obesity. N Engl J Med 2023;389:1069-84.
3. Clinicaltrials.gov. Research study to investigate how well semaglutide works in people living with heart failure and obesity (STEP-HFpEF). Available at: https://clinicaltrials.gov/study/NCT04788511. Accessed August 12, 2025.
4. Pratley RE, Tuttle KR, Rossing P, et al. Effects of semaglutide on heart failure outcomes in diabetes and chronic kidney disease in the FLOW trial. JACC 2024;84(17)-1615-1628.
5. Kittleson MM, Panjrath GS, Amancherla K, et al. 2023 ACC expert consensus decision pathway on management of heart failure with preserved ejection fraction: A report of the American College of Cardiology Solution Set Oversight Committee. J Am Coll Cardiol. 2023 May 9;81(18):1835-1878. doi: 10.1016/j.jacc.2023.03.393.

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 pre-emptively.	08.04.25	08.25
Added pre-emptive criterion for HFpEF for Wegovy and weight management for NN9932. RT4: pre-emptive criteria converted for new FDA approved indication MASH.	08.26.25	11.25
3Q 2026 annual review: drug is still not FDA approved for HFpEF - revised language for members with concurrent T2DM language from "failure" to "member has received optimal diabetic standard of care therapy as evidenced by a trial" to align with verbiage in other indications, added Rybelsus as option for members with concurrent T2DM to reflect it's new FDA indication for reduction of major adverse cardiovascular events in diabetic patients at high risk; Wegovy tablets now FDA approved - new formulation added to policy; added new Wegovy HD injection 7.2 mg formulation for weight management; added ICHRA line of business; references reviewed and updated. RT4: added new formulation Wegovy pre-filled syringe to policy.	06.10.26	08.26

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.