USFHP Prior Authorization Request Form for liraglutide injection **(Saxenda)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Initial therapy approves for 12 months; annual renewal is required. For renewal of therapy an initial Tricare prior authorization approval is required. Non FDA-approved uses are not approved including diabetes mellitus.

Step 1

Please complete patient and physician information (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2

Please complete the clinical assessment:

1. Under penalties for false claims against the United States government, I declare that I have examined the patient, and the statements made are true, correct, and complete to the best of my professional knowledge	☐ **Acknowledged** Proceed to Question **2**	
2. Is the prescriber an MTF or TRICARE Network provider who has billed TRICARE for professional services provided to assess the patient and develop a treatment plan?	☐ Yes (subject to verification) Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. What TRICARE plan is the patient enrolled in? *For a complete list of TRICARE Prime and TRICARE Select plans see:* *https://www.tricare.mil/CoveredServices/IsItCovered/WeightLossProducts*	☐ TRICARE Select **– Proceed to Question 4** ☐ TRICARE Prime **– Proceed to Question 4** ☐ Other TRICARE health plan enrollment that is not TRICARE Select or TRICARE Prime – **STOP** - **Coverage not approved; if patient is diabetic and meets the prior authorization criteria for Trulicity, Victoza, Ozempic, or Mounjaro, please consider these alternatives.**	
4. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Saxenda.*	☐ Yes (subject to verification) Proceed to question **21**	☐ No **Proceed to question 5**

5. How old is the patient?	☐ Less than 12 years of age - **STOP Coverage not approved** ☐ Greater than or equal to 12 years of age and less than 18 years of age - Proceed to question **6** ☐ Greater than or equal to 18 years of age - Proceed to question **12**	
6. Does the patient have a BMI GREATER THAN OR EQUAL TO the 95th percentile standardized for age and sex?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. The provider affirms that the patient has been engaged in behavioral modification and dietary restriction for at least 6 months and has failed to achieve the desired weight loss, will remain engaged throughout course of therapy, AND the provider has documented this in the medical record.	☐ Yes (subject to verification) Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Has the patient tried and failed Qsymia (or its individual generic components) and Wegovy?	☐ Yes Proceed to question **11**	☐ No Proceed to question **9**
9. Has the patient had an adverse reaction to Qsymia (or its individual generic components) and Wegovy?	☐ Yes Proceed to question **18**	☐ No Proceed to question **10**
10. Does the patient have a contraindication to Qsymia (or its individual generic components) and Wegovy?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**

11. Please provide the date of use and duration of therapy or contraindication for each medication listed below. *Note: The dates and durations of therapy for each medication or contraindication to each medication listed below must be provided or your case could be denied.*

Qsymia or one of its individual generic components - topiramate and phentermine:

Date _____ **Duration of therapy** _____

Contraindication _____

Wegovy:

Date _____ **Duration of therapy** _____

Contraindication _____

Proceed to question 18

12. Does the patient have a BMI GREATER THAN or EQUAL to 30, or a BMI GREATER THAN or EQUAL to 27 in the presence of at least one weight-related comorbidity (diabetes, impaired glucose tolerance, dyslipidemia, hypertension, sleep apnea)?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. The provider affirms that the patient has been engaged in behavioral modification and dietary restriction for at least 6 months and has failed to achieve the desired weight loss, will remain engaged throughout course of therapy, AND the provider has documented this in the medical record.	☐ Yes (subject to verification) Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Has the patient tried and failed ALL of the following weight loss medications (generic phentermine [or benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR], Qsymia (or its individual generic components), Contrave, Wegovy and Zepbound?	☐ Yes Proceed to question **17**	☐ No Proceed to question **15**
15. Has the patient experienced an adverse reaction to ALL of the following weight loss medications (generic phentermine [or benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR], Qsymia (or its individual generic components), Contrave, Wegovy and Zepbound?	☐ Yes Proceed to question **18**	☐ No Proceed to question **16**
16. Does the patient have a contraindication to ALL of the following weight loss medications (generic phentermine [or benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR], Qsymia (or its individual generic components), Contrave, Wegovy and Zepbound?	☐ Yes Proceed to question **17**	☐ No **STOP** **Coverage not approved**

17. Please provide the date of use and duration of therapy for all of weight loss medications listed below. ***Note: The dates and durations of therapy for each medication or contraindication to each medication listed below must be provided or your case could be denied.***

Phentermine, benzphetamine, diethylpropion (IR/SR), or phendimetrazine (IR/SR):

Date _____ **Duration of therapy** _____

Contraindication _____

Qsymia (or one of its individual generic components - topiramate and phentermine):

Date _____ **Duration of therapy** _____

Contraindication _____

Contrave (or one of its individual generic components bupropion or naltrexone):

Date _____ **Duration of therapy** _____

Contraindication _____

Wegovy:

Date _____ **Duration of therapy** _____

Contraindication _____

Zepbound:

Date _____ **Duration of therapy** _____

Contraindication _____

Proceed to question 18

18. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 19**
19. Will the requested medication be used with another GLP1RA (for example, Bydureon, Trulicity, Byetta, Adlyxin, Victoza, Soliqua, Xultophy)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **20**
20. Does the patient have a history of or family history of medullary thyroid cancer, or multiple endocrine neoplasia syndrome type 2?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
21. The provider affirms that the patient is currently engaged in behavioral modification, on a reduced calorie diet, AND the provider continues to maintain documentation in the medical record.	☐ Yes (subject to verification) Proceed to question **22**	☐ No **STOP** **Coverage not approved**
22. How old is the patient?	☐ Less than 12 years of age - **STOP Coverage not approved** ☐ Greater than or equal to 12 years of age and less than 18 years of age - Proceed to question **23** ☐ Greater than or equal to 18 years of age - Proceed to question **24**	
23. Has the patient lost GREATER THAN or EQUAL to 4 percent of baseline body weight since starting medication despite 16 weeks of therapy with full dosage titration?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
24. Has the patient lost GREATER THAN or EQUAL to 5 percent of baseline body weight since starting medication?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date