

US Family Health Plan  
 Prior Authorization Request Form for  
**Liraglutide 3 mg injection (Saxenda), Semaglutide 2.4mg injection (Wegovy)**  
**Tirzepatide injection (Zepbound)**

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**

Clinical documentation may be required for approval.

Initial therapy approves for 6 months, renewal approves for 12 months. For renewal of therapy, an initial prior authorization approval is required.

**Step 1 Please complete patient and physician information (please print):**

|          |                      |                       |
|----------|----------------------|-----------------------|
| <b>1</b> | Patient Name: _____  | Physician Name: _____ |
|          | Address: _____       | Address: _____        |
|          | Sponsor ID #: _____  | Phone #: _____        |
|          | Date of Birth: _____ | Secure Fax #: _____   |

**Step 2 Please complete the clinical assessment:**

|  |  |  |
|--|--|--|
| <b>1. 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 the requested medication.</b> | <input type="checkbox"/> Yes<br><small>(subject to verification)</small><br>Proceed to question <b>15</b>  | <input type="checkbox"/> No<br><b>Proceed to question 2</b>                |
| <b>2. How old is the patient?</b>  | <input type="checkbox"/> Less than 12 years of age - <b>STOP Coverage not approved</b><br><input type="checkbox"/> Greater than or equal to 12 years of age and less than 18 years of age - Proceed to question <b>3</b><br><input type="checkbox"/> Greater than or equal to 18 years of age - Proceed to question <b>6</b> |  |
| <b>3. Does the patient have BMI GREATER THAN OR EQUAL TO the 95th percentile standardized for age and sex?</b>   | <input type="checkbox"/> Yes<br>Proceed to question <b>4</b>   | <input type="checkbox"/> No<br><b>STOP</b><br><b>Coverage not approved</b> |
| <b>4. Has the patient tried and failed or has a contraindication to Qsymia or one of its individual generic components?</b>  | <input type="checkbox"/> Yes<br>Proceed to question <b>5</b>   | <input type="checkbox"/> No<br><b>STOP</b><br><b>Coverage not approved</b> |

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5. Please provide the date and duration 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:

Date \_\_\_\_\_ Duration of therapy \_\_\_\_\_ Contraindication \_\_\_\_\_

Proceed to question 9

|   |   |  |
|---|---|--|
| <p>6. Does the patient have BMI GREATER THAN or EQUAL to 30, or a BMI GREATER THAN or EQUAL to 27 for those with risk factors in addition to obesity (diabetes, impaired glucose tolerance, dyslipidemia, hypertension, sleep apnea)?</p> | <p><input type="checkbox"/> Yes<br/>Proceed to question 7</p> | <p><input type="checkbox"/> No<br/><b>STOP</b><br/>Coverage not approved</p> |
| <p>7. Has the patient tried and failed or has a contraindication to phentermine, Qsymia or one of its individual generic components, and Contrave or one of its individual generic components?</p>  | <p><input type="checkbox"/> Yes<br/>Proceed to question 8</p> | <p><input type="checkbox"/> No<br/><b>STOP</b><br/>Coverage not approved</p> |

8. Please provide the date and duration 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.*

Phentermine: 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 and naltrexone:

Date \_\_\_\_\_ Duration of therapy \_\_\_\_\_ Contraindication \_\_\_\_\_

Proceed to question 9

|   |   |  |
|---|---|--|
| <p>9. Does the patient have type 2 diabetes?</p>  | <p><input type="checkbox"/> Yes<br/>Proceed to question 10</p>                | <p><input type="checkbox"/> No<br/>Proceed to question 11</p>                |
| <p>10. Has the patient tried and failed metformin and the preferred GLP1-RAs (Trulicity)?</p>   | <p><input type="checkbox"/> Yes<br/>Proceed to question 11</p>                | <p><input type="checkbox"/> No<br/><b>STOP</b><br/>Coverage not approved</p> |
| <p>11. Will the requested medication be used with another GLP1RA (for example, Bydureon, Trulicity, Byetta, Adlyxin, Victoza, Soliqua, Xultophy)?</p> | <p><input type="checkbox"/> Yes<br/><b>STOP</b><br/>Coverage not approved</p> | <p><input type="checkbox"/> No<br/>Proceed to question 12</p>                |

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|   |   |   |
|---|---|---|
| <p>12. Does the patient have a history of or family history of medullary thyroid cancer, or multiple endocrine neoplasia syndrome type 2?</p>   | <p><input type="checkbox"/> Yes<br/> <b>STOP</b><br/> <b>Coverage not approved</b></p>  | <p><input type="checkbox"/> No<br/> <b>Proceed to question 13</b></p>                 |
| <p>13. Has the patient engaged in a trial of behavioral modification and dietary restriction for at least 6 months and has failed to achieve the desired weight loss, and will remain engaged throughout course of therapy?</p> | <p><input type="checkbox"/> Yes<br/> <b>Proceed to question 14</b></p>  | <p><input type="checkbox"/> No<br/> <b>STOP</b><br/> <b>Coverage not approved</b></p> |
| <p>14. Is the patient pregnant?</p>   | <p><input type="checkbox"/> Yes<br/> <b>STOP</b><br/> <b>Coverage not approved</b></p>  | <p><input type="checkbox"/> No<br/> <b>Sign and date below</b></p>                    |
| <p>15. Is the patient currently engaged in behavioral modification and on a reduced calorie diet?</p>   | <p><input type="checkbox"/> Yes<br/> <b>Proceed to question 16</b></p>  | <p><input type="checkbox"/> No<br/> <b>STOP</b><br/> <b>Coverage not approved</b></p> |
| <p>16. How old is the patient?</p>  | <p><input type="checkbox"/> Less than 12 years of age - <b>STOP Coverage not approved</b></p> <p><input type="checkbox"/> Greater than or equal to 12 years of age and less than 18 years of age - <b>Proceed to question 18</b></p> <p><input type="checkbox"/> Greater than or equal to 18 years of age - <b>Proceed to question 17</b></p> |   |
| <p>17. Has the patient lost <b>GREATER THAN</b> or <b>EQUAL</b> to 4 percent of baseline body weight since starting medication despite 16 weeks of therapy?</p>   | <p><input type="checkbox"/> Yes<br/> <b>Proceed to question 19</b></p>  | <p><input type="checkbox"/> No<br/> <b>STOP</b><br/> <b>Coverage not approved</b></p> |
| <p>18. Has the patient experienced a reduction of <b>AT LEAST</b> 5 percent of baseline BMI?</p>  | <p><input type="checkbox"/> Yes<br/> <b>Proceed to question 19</b></p>  | <p><input type="checkbox"/> No<br/> <b>STOP</b><br/> <b>Coverage not approved</b></p> |
| <p>19. Is the patient pregnant?</p>   | <p><input type="checkbox"/> Yes<br/> <b>STOP</b><br/> <b>Coverage not approved</b></p>  | <p><input type="checkbox"/> No<br/> <b>Sign and date below</b></p>                    |

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

\_\_\_\_\_  
 Prescriber Signature

\_\_\_\_\_  
 Date

[10 May 2024]