US Family Health Plan

Prior Authorization Request Form for

Semaglutide 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

Clinical documentation may be required. Failure to provide could result in denial.
Initial therapy approves for 12 months; annual renewal is required. For renewal of therapy an initial prior authorization approval is required.

Note: 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. 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.*	☐ Yes (subject to verification) Proceed to question **15**	☐ No **Proceed to question 2**
2. 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 **3** ☐ Greater than or equal to 18 years of age - Proceed to question **6**	
3. What is the requested medication?	☐ Wegovy Proceed to question **4**	☐ Zepbound **STOP** **Coverage not approved**
4. Does the patient have a BMI GREATER THAN OR EQUAL TO the 95th percentile standardized for age?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the patient engaged in 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?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**

6. 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 **7**	☐ No **STOP** **Coverage not approved**
7. Has the patient engaged in 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?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Has the patient tried 3 months of generic phentermine, benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR and failed to achieve a 5% reduction in baseline weight?	☐ Yes Proceed to question **9**	☐ No Proceed to question **10**
9. Please provide drug name, the date and duration of therapy. **Phentermine, benzphetamine, diethylpropion (IR/SR), or phendimetrazine (IR/SR).** **Drug name**_____ **Date**_____ **Duration of therapy** _____ Proceed to question **12**		
10. Does the patient have a contraindication to generic phentermine, benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR (for example, arrhythmias, coronary artery disease, heart failure, stroke, uncontrolled hypertension, etc.)?	☐ Yes Proceed to question **12**	☐ No Proceed to question **11**
11. Has the patient experienced an adverse reaction to phentermine, benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR that is not expected to occur with the requested medication?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 13**
13. Will the requested medication be used with another GLP1RA (for example, Trulicity, Ozempic, Mounjaro)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **14**
14. 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**
15. Is the patient currently engaged in behavioral modification and on a reduced calorie diet?	☐ Yes Proceed to question **16**	☐ No **STOP** **Coverage not approved**

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16. 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 **17** ☐ Greater than or equal to 18 years of age - Proceed to question **19**	
17. What is the requested medication?	☐ Wegovy Proceed to question **18**	☐ Zepbound **STOP** **Coverage not approved**
18. Has the patient lost GREATER THAN or EQUAL to 4 percent of baseline body weight since starting medication with full dosage titration?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
19. Has the patient lost GREATER THAN or EQUAL to 5 percent of baseline body weight since starting medication with full dosage titration?	☐ 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 _____

[24 Aug 2024]