US Family Health Plan

Prior Authorization Request Form for

Liraglutide injection (Saxenda), 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

QUESTIONS? **Call 1-877-880-7007**

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

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. Does the patient have BMI GREATER THAN OR EQUAL TO the 95th percentile standardized for age and sex?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Has the patient tried and failed or has a contraindication to Qsymia or one of its individual generic components?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**

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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**

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)?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
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?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

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**

9. Does the patient have type 2 diabetes?	☐ Yes Proceed to question **10**	☐ No Proceed to question **11**
10. Has the patient tried and failed metformin and the preferred GLP1-RAs (Trulicity)?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. 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 **12**

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12. 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 **Proceed to question 13**
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?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Is the patient pregnant?	☐ 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**
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 **18** ☐ Greater than or equal to 18 years of age - Proceed to question **17**	
17. Has the patient lost GREATER THAN or EQUAL to 4 percent of baseline body weight since starting medication despite 16 weeks of therapy?	☐ Yes Proceed to question **19**	☐ No **STOP** **Coverage not approved**
18. Has the patient experienced a reduction of AT LEAST 5 percent of baseline BMI?	☐ Yes Proceed to question **19**	☐ No **STOP** **Coverage not approved**
19. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3

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

Prescriber Signature _____ Date _____