Zepbound® (tirzepatide) Prior Authorization Form

Member Name:______________________ Date of Birth:____________ Member ID#:________________

Drug Information

Pharmacy Billing (NDC:____________________) Start Date (or date of next dose):_________________

Dose:_________________________________ Regimen:___________________________________

Pharmacy Information

Pharmacy NPI:___________________________ Pharmacy Name:______________________________

Pharmacy Phone:________________________ Pharmacy Fax:________________________________

Prescriber Information

Prescriber NPI:____________________ Prescriber Name:_____________________________________

Prescriber Phone:______________ Prescriber Fax:_________________ Specialty:_________________

Criteria

For Initial Authorization: *(Page 1 of 2)*

1. **Please indicate the diagnosis and information:**
   - ☐ **Obstructive Sleep Apnea (OSA)**
   - ☐ **Other:** ______________________________

   a. Does member have moderate to severe OSA with obesity? Yes☐ No☐
   b. Member's apnea-hypopnea index (AHI): __________
      i. Was AHI determined by a polysomnography (PSG) or home sleep apnea testing (HSAT) with a technically adequate device? Yes☐ No☐
   c. Member's body mass index (BMI): ___________
   d. Does member have central or mixed sleep apnea? Yes☐ No☐
   e. Does member have type 1 diabetes mellitus (T1DM) or type 2 diabetes mellitus (T2DM)? Yes☐ No☐
   f. Member's hemoglobin A1C (HbA1c): ___________
   g. Will Zepbound® be used in combination with other tirzepatide-containing products or any other glucagon-like peptide-1 (GLP-1) receptor agonist? Yes☐ No☐
   h. Will Zepbound® be used in conjunction with behavioral changes and/or a reduced calorie diet? Yes☐ No☐ *[clinical documentation (e.g., office notes) of this discussion with the member must be included with the request]*
   i. For Zepbound® vials or Kwikpens, please provide a patient-specific, clinically significant reason why the member cannot use the pen formulation: ____
   ____

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Please complete and return all pages

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

Zepbound® (tirzepatide) Prior Authorization Form

***Member Name:*______________________ *Date of Birth:*____________ *Member ID#:*________________**

Criteria

For Initial Authorization: *(Page 2 of 2)*

2. Request is for:
   - ☐ Titration dosing
   - ☐ Maintenance dosing
3. Initial approvals will be for the titration period to allow initial and escalation dosing. A separate request must be submitted for each dose. Approvals will be for 8 weeks at a time to allow for proper dose escalation. An additional 8 weeks for each dose may be approved for those who experience intolerable adverse effects during dose escalation with proper documentation.

Additional information: ____

____

For Authorization of Maintenance Dosing: *(approvals will be for 1 year)*

1. Date of last dose: ________________________
2. Is the member tolerating maintenance dosing? Yes☐ No☐
3. Is the member adherent to therapy? Yes☐ No☐
4. Is there clinical improvement of OSA (e.g., patient-reported improvement in daytime sleepiness, partner-reported reduction of snoring episodes or pauses in breathing, reduction of AHI events)? Yes☐ No☐
5. Has the member developed T1DM or T2DM? Yes☐ No☐
6. Is the member continuing all of the following?
   - ☐ Reduced calorie diet
   - ☐ Increased physical activity

Additional information: ____

____

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(Page 2 of 2)

Prescriber Signature: _________________________________ Date:_______________________

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.
Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

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