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

JOHNS HOPKINS
HEALTH PLANS
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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. 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 **18**	☐ 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 **9**	
3. Does the patient have a BMI GREATER THAN OR EQUAL TO the 95th percentile standardized for age?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. 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 **5**	☐ No **STOP** **Coverage not approved**
5. Has the patient tried and failed Qsymia (or its individual generic components) and Wegovy?	☐ Yes Proceed to question **8**	☐ No Proceed to question **6**
6. Has the patient had an adverse reaction to Qsymia (or its individual generic components) and Wegovy?	☐ Yes Proceed to question **15**	☐ No Proceed to question **7**

7. Does the patient have a contraindication to Qsymia (or its individual generic components) and Wegovy?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

8. 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 15

9. 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 **10**	☐ No **STOP** **Coverage not approved**
10. 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 **11**	☐ No **STOP** **Coverage not approved**
11. Has the patient tried and failed ALL of the following weight loss (generic phentermine [or benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR], Qsymia, Contrave, Wegovy and Zepbound?	☐ Yes Proceed to question **14**	☐ No Proceed to question **12**
12. 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, Contrave, Wegovy and Zepbound?	☐ Yes Proceed to question **15**	☐ No Proceed to question **13**
13. 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, Contrave, Wegovy and Zepbound?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**

14. 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** _____

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

Date _____ **Duration of therapy** _____

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

Date _____ **Duration of therapy** _____

Wegovy:

Date _____ **Duration of therapy** _____

Zepbound:

Date _____ **Duration of therapy** _____

Proceed to question 15

15. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question16**
16. 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 **17**
17. 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**
18. Is the patient currently engaged in behavioral modification and on a reduced calorie diet?	☐ Yes Proceed to question **19**	☐ No **STOP** **Coverage not approved**
19. 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 **20** ☐ Greater than or equal to 18 years of age - Proceed to question **21**	
20. 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**

21. 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 _____

[28 Aug 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: