TRICARE Prior Authorization Request Form for
semaglutide injection **(Wegovy),** tirzepatide injection (**Zepbound**)

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

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. 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]

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