Reset Form Print Form

Government of District of Columbia Department of Health Care Finance

Zepbound (tirzepatide) for OSA + BMI ≥ 27 kg/m^2 **only**

Initial Prior Authorization Request

Request Date: _____

MEMBER INFORMATION

Member Medicaid ID: _____

Date of Birth: _____

Member Last Name: _____

Member First Name: _____ Middle Initial: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Prescriber Phone: _____

Prescriber Fax: _____

Prescriber DEA Number: _____

Prescriber NPI Number: _____

Prescriber Specialty: _____

PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy Phone: _____

Pharmacy Fax: _____

Pharmacy NPI Number: _____

Refer to FDA www.fda.gov for prescribing details and approved indications.

PRIOR AUTHORIZATION CRITERIA

Zepbound is covered only for the indication below:

- Moderate to severe obstructive sleep apnea **and** either obesity (body mass index [BMI] of ≥ 30 kg/m^2) or overweight (BMI of ≥ 27 kg/m^2) in adults (≥ 18 years old).

Note: Anti-obesity drugs are excluded from coverage for the District DHCF Pharmacy Program.

Member's Name (Last, First): _____

1. Is the member using Zepbound with another glucagon-like peptide-1 (GLP-1) receptor agonist or GLP-1 receptor agonist combination (e.g., insulin with a GLP-1 receptor agonist)?
   ☐ Yes ☐ No
2. Does the member have a diagnosis of moderate to severe obstructive sleep apnea by or in consultation with a sleep specialist?
   ☐ Yes ☐ No
3. Has the member undergone HSAT or PSG screening?
   ☐ Yes ☐ No

   If yes, provide documentation of HSAT or PSG screening via fax to 866-535-7622.
4. Is the member currently established on Zepbound for moderate to severe obstructive sleep apnea/hypopnea syndrome (OSAHS)?
   ☐ Yes ☐ No
5. Is the member using Zepbound in combination with sleep hygiene modifications (e.g., sleep positioning to avoid a non-supine position, avoidance of alcohol and sedatives before bed)?
   ☐ Yes ☐ No
6. What other medications has the member tried and failed?

   _____
7. Does the member have a personal or family history of medullary thyroid carcinoma (MTC) or multiple endocrine neoplasia syndrome type 2 (MEN 2)?
   ☐ Yes ☐ No

Length of authorization: up to 6 months

PRIOR AUTHORIZATION RENEWAL

1. Does the member continue to meet the initial review criteria?
   ☐ Yes ☐ No
2. Has the member experienced any treatment-restricting adverse effects (e.g., thyroid C-cell tumors, acute pancreatitis, acute gallbladder disease, acute kidney injury, hypoglycemia in members without type II diabetes mellitus, hypersensitivity reactions)?
   ☐ Yes ☐ No
3. Is the member's dosage appropriate as per FDA label?
   ☐ Yes ☐ No

Member's Name (Last, First): _____

DOSAGE AND ADMINISTRATION

- Available as 2.5 mg, 5 mg, 7.5 mg, 10 mg, 12.5 mg, or 15 mg per 0.5 mL in single-dose pen.
- Refer to product labeling at https://www.accessdata.fda.gov/scripts/cder/daf/.

I certify that, to the best of my knowledge, all the information I have provided on this request is complete and factual.

Prescriber's Signature: _____ **Date:** _____

Please fax this form to:
District of Columbia Pharmacy Program
Fax: 866-535-7622
Phone: 800-273-4962