

TRICARE Prior Authorization Request Form for
semaglutide injection/tablets (**Wegovy**), tirzepatide injection (**Zepbound Pen Injector**)



6311

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) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

PLEASE NOTE: For Active Duty Service Members, even if coverage will NOT BE APPROVED per this form, it still must be initially submitted to the TPharm Contractor for review. Subsequent reconsideration is allowed at the appropriate Military Treatment Facility. Providers must continue to follow Military Department-specific policies that set the requirements for participation in weight loss programs for Active-Duty Service Members.

For initial review by the TPharm Contractor;

- The provider may **call: 1-866-684-4488**
or the completed form may be **faxed to:**
1-866-684-4477

- The patient may attach the completed form
to the prescription and **mail it to: Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954**
or **email the form only to:**
TPharmPA@express-scripts.com

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):

1	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID #: _____	Phone #: _____
	Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. Under penalties for false claims against the United States government, I declare that I have examined the patient, and the statements made are true, correct, and complete to the best of my professional knowledge	☐ Acknowledged Proceed to Question 2	
2. Is the prescriber an MTF or TRICARE Network provider who has billed TRICARE for professional services provided to assess the patient and develop a treatment plan?	☐ Yes (subject to verification) Proceed to question 3	☐ No STOP – Coverage not approved
3. What TRICARE plan is the patient enrolled in? <i>For a complete list of TRICARE Prime and TRICARE Select plans see:</i> https://www.tricare.mil/CoveredServices/IsItCovered/WeightLossProducts	☐ TRICARE Select – Proceed to Question 4 ☐ TRICARE Prime – Proceed to Question 4 ☐ Other TRICARE health plan enrollment that is not TRICARE Select or TRICARE Prime – STOP - Coverage not approved; if patient is diabetic and meets the prior authorization criteria for Trulicity, Victoza, Ozempic, or Mounjaro, please consider these alternatives.	
4. Has the patient received this medication under the TRICARE benefit in the last 6 months? <i>Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.</i>	☐ Yes (subject to verification) Proceed to question 27	☐ No Proceed to question 5
5. What is the indication or diagnosis?	☐ Weight management - Proceed to question 6 ☐ Moderate to severe obstructive sleep apnea (OSA) in adults with obesity - Proceed to question 19 ☐ Other diagnosis - STOP - Coverage not approved	

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6. 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 7 ☐ 18 years of age or older - Proceed to question 10	
7. What is the requested medication?	☐ Wegovy Injection Proceed to question 8	☐ Zepbound Pen Injector or Wegovy Tablets STOP Coverage not approved
8. Does the patient have a BMI GREATER THAN OR EQUAL TO the 95th percentile standardized for age and sex?	☐ Yes Proceed to question 9	☐ No STOP Coverage not approved
9. The provider affirms that the patient has been engaged in behavioral modification and dietary restriction for at least 6 months and has failed to achieve the desired weight loss, will remain engaged throughout course of therapy, AND the provider has documented this in the medical record.	☐ Yes (subject to verification) Proceed to question 24	☐ No STOP Coverage not approved
10. What is the patient's body mass index (BMI)?	☐ Less Than 27 – STOP - Coverage not approved ☐ 27 to 29 with an additional comorbidity - Proceed to question 11 ☐ 30 to 34 - Proceed to question 13 ☐ 35 to 39 – Proceed to question 13 ☐ 40 or GREATER - Proceed to question 13	
11. Does the patient have AT LEAST ONE weight-related comorbidity?	☐ Yes Proceed to question 12	☐ No STOP Coverage not approved
12. In addition to overweight with BMI GREATER THAN 27, what are the major condition(s)/comorbidities being treated (select all that apply)?	☐ Diabetes or impaired glucose tolerance ☐ Obstructive sleep apnea ☐ Osteoarthritis ☐ Metabolic syndrome ☐ Dyslipidemia ☐ Hypertension ☐ Metabolic dysfunction-associated steatohepatitis (MASH) ☐ Established cardiovascular disease with a history of stroke ☐ Established cardiovascular disease with a history of myocardial infarction ☐ Established cardiovascular disease with a history of peripheral artery disease Proceed to question 14	

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13. What are the major condition(s)/comorbidities being treated (select all that apply)?	☐ Obesity ☐ Diabetes or impaired glucose tolerance ☐ Obstructive sleep apnea ☐ Osteoarthritis ☐ Metabolic syndrome ☐ Dyslipidemia ☐ Hypertension ☐ Metabolic dysfunction-associated steatohepatitis (MASH) ☐ Established cardiovascular disease with a history of stroke ☐ Established cardiovascular disease with a history of myocardial infarction ☐ Established cardiovascular disease with a history of peripheral artery disease Proceed to question 14	
14. The provider affirms that the patient has been engaged in behavioral modification and dietary restriction for at least 6 months and has failed to achieve the desired weight loss, will remain engaged throughout course of therapy, AND the provider has documented this in the medical record.	☐ Yes (subject to verification) Proceed to question 15	☐ No STOP Coverage not approved
15. 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 16	☐ No Proceed to question 17
16. 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 24		
17. 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 24	☐ No Proceed to question 18
18. 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 24	☐ No STOP Coverage not approved
19. What is the requested medication?	☐ Wegovy STOP Coverage not approved	☐ Zepbound Pen Injector Proceed to question 20

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20. Is the patient 18 years of age or older?	☐ Yes Proceed to question 21	☐ No STOP Coverage not approved
21. Does the patient have moderate to severe OSA (documented apnea-hypopnea index GREATER THAN OR EQUAL TO 15 events per hour)?	☐ Yes Proceed to question 22	☐ No STOP Coverage not approved
22. Does the patient have a BMI greater than or equal to 30?	☐ Yes Proceed to question 23	☐ No STOP Coverage not approved
23. The provider affirms that the patient has been engaged in behavioral modification and dietary restriction for at least 6 months and has failed to achieve the desired weight loss, will remain engaged throughout course of therapy, AND the provider has documented this in the medical record.	☐ Yes (Subject to verification) Proceed to question 24	☐ No STOP Coverage not approved
24. Is the patient pregnant?	☐ Yes STOP Coverage not approved	☐ No Proceed to question 25
25. Will the requested medication be used with another GLP1RA (for example, Trulicity, Victoza, Soliqua, Xultophy)?	☐ Yes STOP Coverage not approved	☐ No Proceed to question 26
26. 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
27. What is the indication or diagnosis?	☐ Weight management - Proceed to question 28 ☐ Moderate to severe obstructive sleep apnea (OSA) in adults with obesity - Proceed to question 34 ☐ Other diagnosis - STOP - Coverage not approved	
28. The provider affirms that the patient is currently engaged in behavioral modification, on a reduced calorie diet, AND the provider continues to maintain documentation in the medical record.	☐ Yes (subject to verification) Proceed to question 29	☐ No STOP Coverage not approved
29. 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 30 ☐ 18 years of age or older - Proceed to question 32	

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30. What is the requested medication?	☐ Wegovy Injection Proceed to question 31	☐ Zepbound Pen Injector or Wegovy Tablet STOP Coverage not approved
31. 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
32. What is the patient's current body mass index (BMI)?	☐ Less Than 27 – Proceed to question 33 ☐ 27 to 29 - Proceed to question 33 ☐ 30 to 34 - Proceed to question 33 ☐ 35 to 39 – Proceed to question 33 ☐ 40 or GREATER - Proceed to question 33	
33. 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
34. What is the requested medication?	☐ Wegovy STOP Coverage not approved	☐ Zepbound Pen Injector Proceed to question 35
35. Has the patient shown improvement in OSA symptoms based on the improvement of apnea hypopnea index?	☐ Yes Sign and date below	☐ No STOP Coverage not approved

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

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Prescriber Signature

Date

[28 January 2026]