

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):**

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

**Step 2 Please complete the clinical assessment:**

<p><b>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</b></p>	<input type="checkbox"/> <b>Acknowledged</b> Proceed to Question 2	
<p><b>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?</b></p>	<input type="checkbox"/> Yes (subject to verification) Proceed to question 3	<input type="checkbox"/> No <b>STOP – Coverage not approved</b>
<p><b>3. What TRICARE plan is the patient enrolled in?</b> <i>For a complete list of TRICARE Prime and TRICARE Select plans see:</i> <a href="https://www.tricare.mil/CoveredServices/IsItCovered/WeightLossProducts">https://www.tricare.mil/CoveredServices/IsItCovered/WeightLossProducts</a></p>	<input type="checkbox"/> TRICARE Select – <b>Proceed to Question 4</b> <input type="checkbox"/> TRICARE Prime – <b>Proceed to Question 4</b> <input type="checkbox"/> Other TRICARE health plan enrollment that is not TRICARE Select or TRICARE Prime – <b>STOP - Coverage not approved; if patient is diabetic and meets the prior authorization criteria for Trulicity, Victoza, Ozempic, or Mounjaro, please consider these alternatives.</b>	
<p><b>4. 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.</b></p>	<input type="checkbox"/> Yes (subject to verification) Proceed to question 29	<input type="checkbox"/> No Proceed to question 5
<p><b>5. What is the indication or diagnosis?</b></p>	<input type="checkbox"/> Weight management - Proceed to question 6 <input type="checkbox"/> Moderate to severe obstructive sleep apnea (OSA) in adults with obesity - Proceed to question 21 <input type="checkbox"/> Other diagnosis - <b>STOP - Coverage not approved</b>	

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<p><b>6. How old is the patient?</b></p>	<input type="checkbox"/> Less than 12 years of age - <b>STOP - Coverage not approved</b> <input type="checkbox"/> Greater than or equal to 12 years of age and less than 18 years of age - Proceed to question 7 <input type="checkbox"/> 18 years of age or older - Proceed to question 10	
<p><b>7. What is the requested medication?</b></p>	<input type="checkbox"/> Wegovy Injection Proceed to question 8	<input type="checkbox"/> Zepbound Pen Injector or Wegovy Tablets <b>STOP</b> <b>Coverage not approved</b>
<p><b>8. Does the patient have a BMI GREATER THAN OR EQUAL TO the 95th percentile standardized for age and sex?</b></p>	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No <b>STOP</b> <b>Coverage not approved</b>
<p><b>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.</b></p>	<input type="checkbox"/> Yes (subject to verification) Proceed to question 26	<input type="checkbox"/> No <b>STOP</b> <b>Coverage not approved</b>
<p><b>10. What is the patient's body mass index (BMI)?</b></p>	<input type="checkbox"/> Less Than 27 – <b>STOP - Coverage not approved</b> <input type="checkbox"/> 27 to 29 with an additional comorbidity - Proceed to question 11 <input type="checkbox"/> 30 to 34 - Proceed to question 13 <input type="checkbox"/> 35 to 39 – Proceed to question 13 <input type="checkbox"/> 40 or GREATER - Proceed to question 13	
<p><b>11. Does the patient have AT LEAST ONE weight-related comorbidity?</b></p>	<input type="checkbox"/> Yes Proceed to question 12	<input type="checkbox"/> No <b>STOP</b> <b>Coverage not approved</b>
<p><b>12. In addition to overweight with BMI GREATER THAN 27, what are the major condition(s)/comorbidities being treated (select all that apply)?</b></p>	<input type="checkbox"/> Diabetes or impaired glucose tolerance <input type="checkbox"/> Obstructive sleep apnea <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Metabolic syndrome <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Hypertension <input type="checkbox"/> Metabolic dysfunction-associated steatohepatitis (MASH) <input type="checkbox"/> Established cardiovascular disease with a history of stroke <input type="checkbox"/> Established cardiovascular disease with a history of myocardial infarction <input type="checkbox"/> Established cardiovascular disease with a history of peripheral artery disease <p style="text-align: right;">Proceed to question 14</p>	

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<p><b>13. What are the major condition(s)/comorbidities being treated (select all that apply)?</b></p>	<input type="checkbox"/> Obesity <input type="checkbox"/> Diabetes or impaired glucose tolerance <input type="checkbox"/> Obstructive sleep apnea <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Metabolic syndrome <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Hypertension <input type="checkbox"/> Metabolic dysfunction-associated steatohepatitis (MASH) <input type="checkbox"/> Established cardiovascular disease with a history of stroke <input type="checkbox"/> Established cardiovascular disease with a history of myocardial infarction <input type="checkbox"/> Established cardiovascular disease with a history of peripheral artery disease <p style="text-align: right;">Proceed to question 14</p>	
<p><b>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.</b></p>	<input type="checkbox"/> Yes (subject to verification) Proceed to question 15	<input type="checkbox"/> No <p style="text-align: center;"><b>STOP</b></p> Coverage not approved
<p><b>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?</b></p>	<input type="checkbox"/> Yes Proceed to question 16	<input type="checkbox"/> No Proceed to question 19
<p><b>16. Please provide drug name.</b>                  Phentermine, benzphetamine, diethylpropion (IR/SR), or phendimetrazine (IR/SR).                  Drug name _____  <p style="text-align: right;">Proceed to question 17</p></p>		
<p><b>17. Please provide the date of therapy.</b>                  Date _____  <p style="text-align: right;">Proceed to question 18</p></p>		
<p><b>18. Please provide the duration of therapy.</b>                  Duration of therapy _____  <p style="text-align: right;">Proceed to question 26</p></p>		
<p><b>19. 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.)?</b></p>	<input type="checkbox"/> Yes Proceed to question 26	<input type="checkbox"/> No Proceed to question 20
<p><b>20. 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?</b></p>	<input type="checkbox"/> Yes Proceed to question 26	<input type="checkbox"/> No <p style="text-align: center;"><b>STOP</b></p> Coverage not approved

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<p>21. What is the requested medication?</p>	<p><input type="checkbox"/> Wegovy <b>STOP</b> Coverage not approved</p>	<p><input type="checkbox"/> Zepbound Pen Injector Proceed to question 22</p>
<p>22. Is the patient 18 years of age or older?</p>	<p><input type="checkbox"/> Yes Proceed to question 23</p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>23. Does the patient have moderate to severe OSA (documented apnea-hypopnea index GREATER THAN OR EQUAL TO 15 events per hour)?</p>	<p><input type="checkbox"/> Yes Proceed to question 24</p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>24. Does the patient have a BMI greater than or equal to 30?</p>	<p><input type="checkbox"/> Yes Proceed to question 25</p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>25. 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.</p>	<p><input type="checkbox"/> Yes (Subject to verification) Proceed to question 26</p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>26. Is the patient pregnant?</p>	<p><input type="checkbox"/> Yes <b>STOP</b> Coverage not approved</p>	<p><input type="checkbox"/> No Proceed to question 27</p>
<p>27. Will the requested medication be used with another GLP1RA (for example, Trulicity, Victoza, Soliqua, Xultophy)?</p>	<p><input type="checkbox"/> Yes <b>STOP</b> Coverage not approved</p>	<p><input type="checkbox"/> No Proceed to question 28</p>
<p>28. Does the patient have a history of or family history of medullary thyroid cancer, or multiple endocrine neoplasia syndrome type 2?</p>	<p><input type="checkbox"/> Yes <b>STOP</b> Coverage not approved</p>	<p><input type="checkbox"/> No Sign and date below</p>
<p>29. What is the indication or diagnosis?</p>	<p><input type="checkbox"/> Weight management - Proceed to question 30  <input type="checkbox"/> Moderate to severe obstructive sleep apnea (OSA) in adults with obesity - Proceed to question 36  <input type="checkbox"/> Other diagnosis - <b>STOP - Coverage not approved</b></p>	
<p>30. 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.</p>	<p><input type="checkbox"/> Yes (subject to verification) Proceed to question 31</p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>31. How old is the patient?</p>	<p><input type="checkbox"/> Less than 12 years of age - <b>STOP Coverage not approved</b>  <input type="checkbox"/> Greater than or equal to 12 years of age and less than 18 years of age - Proceed to question 32  <input type="checkbox"/> 18 years of age or older - Proceed to question 34</p>	

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<b>32. What is the requested medication?</b>	<input type="checkbox"/> Wegovy Injection Proceed to question <b>33</b>	<input type="checkbox"/> Zepbound Pen Injector or Wegovy Tablet <p style="text-align: center;"><b>STOP</b></p> Coverage not approved
<b>33. Has the patient lost GREATER THAN or EQUAL to 4 percent of baseline body weight since starting medication with full dosage titration?</b>	<input type="checkbox"/> Yes - <b>Sign and date below</b> <input type="checkbox"/> No – <b>STOP - Coverage not approved</b> <input type="checkbox"/> The patient has had an interruption of therapy and is restarting therapy – <b>please submit this request using the initial therapy pathway -</b> Proceed to question <b>5</b>	
<b>34. What is the patient’s current body mass index (BMI)?</b>	<input type="checkbox"/> Less Than 27 – Proceed to question <b>35</b> <input type="checkbox"/> 27 to 29 - Proceed to question <b>35</b> <input type="checkbox"/> 30 to 34 - Proceed to question <b>35</b> <input type="checkbox"/> 35 to 39 – Proceed to question <b>35</b> <input type="checkbox"/> 40 or GREATER - Proceed to question <b>35</b>	
<b>35. Has the patient lost GREATER THAN or EQUAL to 5 percent of baseline body weight since starting medication with full dosage titration?</b>	<input type="checkbox"/> Yes - <b>Sign and date below</b> <input type="checkbox"/> No – <b>STOP - Coverage not approved</b> <input type="checkbox"/> The patient has had an interruption of therapy and is restarting therapy – <b>please submit this request using the initial therapy pathway -</b> Proceed to question <b>5</b>	
<b>36. What is the requested medication?</b>	<input type="checkbox"/> Wegovy <p style="text-align: center;"><b>STOP</b></p> Coverage not approved	<input type="checkbox"/> Zepbound Pen Injector Proceed to question <b>37</b>
<b>37. Has the patient shown improvement in OSA symptoms based on the improvement of apnea hypopnea index?</b>	<input type="checkbox"/> Yes <b>Sign and date below</b>	<input type="checkbox"/> No <p style="text-align: center;"><b>STOP</b></p> Coverage not approved

**Step 3** I certify the above is true to the best of my knowledge. Please sign and date:

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

[12 March 2026]