

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



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. 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.	<input type="checkbox"/> Yes (subject to verification) Proceed to question 15	<input type="checkbox"/> No Proceed to question 2
2. How old is the patient?	<input type="checkbox"/> Less than 12 years of age - STOP Coverage not approved <input type="checkbox"/> Greater than or equal to 12 years of age and less than 18 years of age - Proceed to question 3 <input type="checkbox"/> Greater than or equal to 18 years of age - Proceed to question 6	
3. What is the requested medication?	<input type="checkbox"/> Wegovy Proceed to question 4	<input type="checkbox"/> Zepbound STOP Coverage not approved
4. Does the patient have a BMI GREATER THAN OR EQUAL TO the 95th percentile standardized for age?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Proceed to question 12	<input type="checkbox"/> No STOP Coverage not approved

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<p>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)?</p>	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved
<p>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?</p>	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No STOP Coverage not approved
<p>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?</p>	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No Proceed to question 10
<p>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 _____</p> <p style="text-align: center;">Proceed to question 12</p>		
<p>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.)?</p>	<input type="checkbox"/> Yes Proceed to question 12	<input type="checkbox"/> No Proceed to question 11
<p>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?</p>	<input type="checkbox"/> Yes Proceed to question 12	<input type="checkbox"/> No STOP Coverage not approved
<p>12. Is the patient pregnant?</p>	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 13
<p>13. Will the requested medication be used with another GLP1RA (for example, Trulicity, Ozempic, Mounjaro)?</p>	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 14
<p>14. Does the patient have a history of or family history of medullary thyroid cancer, or multiple endocrine neoplasia syndrome type 2?</p>	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Sign and date below
<p>15. Is the patient currently engaged in behavioral modification and on a reduced calorie diet?</p>	<input type="checkbox"/> Yes Proceed to question 16	<input type="checkbox"/> No STOP Coverage not approved

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16. How old is the patient?	<input type="checkbox"/> Less than 12 years of age - STOP Coverage not approved <input type="checkbox"/> Greater than or equal to 12 years of age and less than 18 years of age - Proceed to question 17 <input type="checkbox"/> Greater than or equal to 18 years of age - Proceed to question 19	
17. What is the requested medication?	<input type="checkbox"/> Wegovy Proceed to question 18	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

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

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Prescriber Signature

Date

[24 Aug 2024]