

Zepbound® (tirzepatide) Prior Authorization Form**Member Name:** _____ **Date of Birth:** _____ **Member ID#:** _____**Drug Information****Pharmacy Billing (NDC:** _____ **) Start Date (or date of next dose):** _____**Dose:** _____ **Regimen:** _____**Pharmacy Information****Pharmacy NPI:** _____ **Pharmacy Name:** _____**Pharmacy Phone:** _____ **Pharmacy Fax:** _____**Prescriber Information****Prescriber NPI:** _____ **Prescriber Name:** _____**Prescriber Phone:** _____ **Prescriber Fax:** _____ **Specialty:** _____**Criteria****For Initial Authorization:** (Page 1 of 2)**1. Please indicate the diagnosis and information:** **Obstructive Sleep Apnea (OSA)** **Other:** _____

a. Does member have moderate to severe OSA with obesity? Yes ___ No ___

b. Member's apnea-hypopnea index (AHI): _____

i. Was AHI determined by a polysomnography (PSG) or home sleep apnea testing (HSAT) with a technically adequate device? Yes ___ No ___

c. Member's body mass index (BMI): _____

d. Does member have central or mixed sleep apnea? Yes ___ No ___

e. Does member have type 1 diabetes mellitus (T1DM) or type 2 diabetes mellitus (T2DM)?
Yes ___ No ___

f. Member's hemoglobin A1C (HbA1c): _____

g. Will Zepbound® be used in combination with other tirzepatide-containing products or any other glucagon-like peptide-1 (GLP-1) receptor agonist? Yes ___ No ___

h. Will Zepbound® be used in conjunction with behavioral changes and/or a reduced calorie diet?
Yes ___ No ___ [clinical documentation (e.g., office notes) of this discussion with the member must be included with the request]i. For Zepbound® vials or Kwikpens, please provide a patient-specific, clinically significant reason why the member cannot use the pen formulation: _____
_____**(Page 1 of 2)****Please complete and return all pages****PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:**University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization UnitFax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4**CONFIDENTIALITY NOTICE**

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Zepbound® (tirzepatide) Prior Authorization Form**Member Name:** _____ **Date of Birth:** _____ **Member ID#:** _____**Criteria****For Initial Authorization: (Page 2 of 2)**

2. Request is for:
- Titration dosing
 - Maintenance dosing
3. Initial approvals will be for the titration period to allow initial and escalation dosing. A separate request must be submitted for each dose. Approvals will be for 8 weeks at a time to allow for proper dose escalation. An additional 8 weeks for each dose may be approved for those who experience intolerable adverse effects during dose escalation with proper documentation.

Additional information: _____

For Authorization of Maintenance Dosing: (approvals will be for 1 year)

1. Date of last dose: _____
2. Is the member tolerating maintenance dosing? Yes ___ No ___
3. Is the member adherent to therapy? Yes ___ No ___
4. Is there clinical improvement of OSA (e.g., patient-reported improvement in daytime sleepiness, partner-reported reduction of snoring episodes or pauses in breathing, reduction of AHI events)? Yes ___ No ___
5. Has the member developed T1DM or T2DM? Yes ___ No ___
6. Is the member continuing all of the following?
 - Reduced calorie diet
 - Increased physical activity

Additional information: _____

(Page 2 of 2)**Prescriber Signature:** _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

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