PRIOR AUTHORIZATION REQUEST

Zepbound

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

CRITERIA FOR APPROVAL

1 Is this request for initial therapy or for a continuation of therapy?
[] Initial (If checked, go to 11)

[] Continuation (If checked, go to 2)

2 Has the patient been receiving medication samples for the requested medication? Yes No
[If yes, skip to question 10.]

If you have any questions, call: 1-888-258-8250

Version 07.2025

PRIOR AUTHORIZATION REQUEST

3	Has the patient been established on therapy for at least 6 months? ACTION REQUIRED: Submit supporting documentation. [If no, skip to question 11.]	Yes	No
4	What is the diagnosis or indication? [] Moderate to severe obstructive sleep apnea (OSA) (If checked, go to 5) [] Other (If checked, no further questions)		
5	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
6	Does the patient have documented height and weight measurements obtained within 90 days of this prior authorization request? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
7	Does the patient have a documented BMI greater than or equal to 30 kg/m2? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
8	Has the patient experienced clinically significant benefit from the medication? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
9	Is the requested medication being prescribed by or in consultation with a sleep specialist, pulmonologist, or other provider experienced in treating obstructive sleep apnea (OSA)? [No further questions.]	Yes	No
10	Has the patient experienced clinically significant benefit from the medication? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
11	What is the diagnosis or indication? [] Moderate to severe obstructive sleep apnea (OSA) (If checked, go to 12) [] Other (If checked, no further questions)		
12	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
13	Does the patient have documented height and weight measurements obtained within 90 days of this prior authorization request? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No

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PRIOR AUTHORIZATION REQUEST

14	Does the patient have a documented BMI greater than or equal to 30 kg/m2? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Has the patient been diagnosed with moderate to severe obstructive sleep apnea (OSA) by polysomnography with an apnea-hypopnea index (AHI) of 15 or more events per hour? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
16	Does the provider attest that the requested medication has been evaluated as clinically appropriate for this patient and that the requested medication will be prescribed in accordance with the Food and Drug Administration (FDA) approved dosing? [If no, no further questions.]	Yes	No
17	Will the patient be using the requested medication concurrently with other tirzepatide-containing products or glucagon-like peptide-1 (GLP-1) receptor agonists? [If yes, no further questions.]	Yes	No
18	Is the requested medication being prescribed by or in consultation with a sleep specialist, pulmonologist, or other provider experienced in treating obstructive sleep apnea (OSA)?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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