Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Zepbound

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is Zepbound being used for weight loss ONLY?

☐ Yes ☐ No

Q2. Is the request for renewal? If YES, go to 3. If NO, go to 10.

☐ Yes ☐ No

Q3. Has the patient experienced an improvement in their Apnea Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) from baseline (defined as less than 15 events per hour OR at least a 50% reduction in events) since initiating therapy? Documentation of CPAP report or sleep study since initiating Zepbound must be attached.

☐ Yes ☐ No

Q4. Is the patient compliant with standard OSA treatments as appropriate (such as CPAP, oral appliances)?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. Does the patient continue to follow a reduced-calorie diet and increased physical activity plan?

☐ Yes ☐ No

Q6. Has the patient had at least a 5% reduction in body weight from baseline? Chart notes documenting BMI must be attached.

☐ Yes ☐ No

Q7. Is the patient currently on the recommended maintenance dose for OSA? The recommended maintenance dosage is 10 mg, 12.5 mg, or 15 mg injected subcutaneously once weekly.

☐ Yes ☐ No

Q8. Is there documentation showing a plan to titrate the patient to the recommended maintenance dosage?

☐ Yes ☐ No

Q9. Is the patient adherent to Zepbound? Adherence is based on pharmacy claims data.

☐ Yes ☐ No

Q10. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q11. Does the patient have a history of type 2 diabetes mellitus (T2DM)?

☐ Yes ☐ No

Q12. Does the patient have a diagnosis of moderate to severe obstructive sleep apnea (OSA)? Chart notes documenting diagnosis must be attached.

☐ Yes ☐ No

Q13. Does the patient have central or mixed sleep apnea? Documentation must be attached.

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☐ Yes ☐ No

Q14. Is Zepbound being prescribed by or in consultation with a sleep specialist, pulmonologist or endocrinologist?

☐ Yes ☐ No

Q15. Is there a baseline polysomnography or recording time documenting (without the use of CPAP during testing) an Apnea Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) greater than or equal to 15 events per hour? Documentation of baseline polysomnography or recording time must be attached.

☐ Yes ☐ No

Q16. Is the patient currently using and compliant with continuous positive airway pressure (CPAP)? Compliance is defined as CPAP device was used for 70 percent of nights for four or more hours per night, for two or more months. Documentation must be attached.

☐ Yes ☐ No

Q17. Is there a baseline polysomnography or recording time documenting Apnea Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) with the use of CPAP? Documentation must be attached.

☐ Yes ☐ No

Q18. Does the patient have a medical reason CPAP cannot be used or a documented therapeutic failure of an oral appliance for OSA?

☐ Yes ☐ No

Q19. Is the patient's baseline BMI greater than or equal to 30 kg/m2? Chart notes documenting BMI must be attached and within the last 6 months.

☐ Yes ☐ No

Q20. Will the patient follow a reduced-calorie diet and increased physical activity plan?

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☐ Yes ☐ No

Q21. Is the patient currently filling other tirzepatide-containing products or any other GLP-1 receptor agonists?

☐ Yes ☐ No

Q22. Additional Information:

_____ _____

Prescriber Signature Date

v2025