HIGHMARK | HIGHMARK

Medication Prior Authorization Form
Fax to 1-866-240-8123

Zepbound

Member Information:

Subscriber's ID Number			Subscriber's Group Number
Member's Name		Phone	Date of Birth
Address	City	State	Zip Code

Provider Information:

Physician's Name	NPI	Phone	Fax
Address	City	State	Zip Code
Suite / Building	Physician's Signature		Date

Medication Information:

Drug Name	Drug Strength	Requested Quantity	Requested Day Supply
			☐ 30 days ☐ 90 days ☐ Other: _____
Directions			
Diagnosis			

Clinical Information:

1. Is the member using Zepbound in combination with a lifestyle modification program that encourages reduced calorie diet and increased physical activity (for example, nutritional counseling, participation in a comprehensive weight management program)?

   ☐ **Yes** ☐ **No**

2. Please specify how long (in months) this member has actively participated in a lifestyle modification program that encourages both a reduced calorie diet and increased physical activity (for example, nutritional counseling, participation in a comprehensive weight management program) **prior** to initiating therapy with Zepbound:

   _____ months

   ***Please attach documentation to support the answers to questions 1 and 2.**
   Acceptable forms of documentation are listed below.
   One from each category is required.

   Diet
   - Provider chart notes detailing specific dietary adjustments and/or calorie deficit
   - Recurring receipts for a subscription to a lifestyle modification program, such as Noom, Weight Watchers, Vida, Lark, Signos, Wondr, Livongo, Omada, Newtopia, Virta, plan sponsored coaching programs such as My Weight Management Journey or Penn State Health obesity medicine institute (for example, monthly, provided for each month)
   - Dietary log maintained by member detailing specific diet and/or calorie deficit
   - Recurring appointments for private nutritional counseling or medical nutrition therapy (for example, receipt or chart documentation provided monthly)

   Physical Activity
   - Provider chart notes specifying type, duration, and frequency of physical activity
   - Recurring receipts for a gym membership (for example, monthly, provided for each month) and notes specifying type, duration, and frequency of physical activity
   - Summary report from a wearable device specifying frequency of physical activity (for example, elevated heart rate for over 20 minutes for at least 3 times a week for a month)
   - Recurring appointments with a personal trainer (for example, receipt provided monthly) and notes specifying type, duration, and frequency of physical activity)

3. Please list any weight-related comorbidities this member has, if applicable:
   Please attach documentation (for example, chart notes) to support this information.

   _____

   _____

4. Does the member have a diagnosis of prediabetes?

   ☐ **Yes** ☐ **No**

   If **YES**:

   a. Was the member's diagnosis of prediabetes confirmed by any of the following tests within the past 6 months?
      *Please select **ALL** that apply:*

      ☐ An A1c of 5.7% to 6.4%

      ☐ A fasting plasma glucose (FPG) of 100 mg/dL to 125 mg/dL

      ☐ An oral glucose tolerance test (OGTT) of 140 to 199 mg/dL

      ☐ None of the above

      If prediabetes was confirmed by any of these tests, please attach documentation (for example, chart notes) to support this information.

5. Does the member have a diagnosis of type 2 diabetes mellitus?

☐ **Yes** ☐ **No**

6. Please provide any other medications that the member has tried and failed with dates of therapy, if applicable:

Previous weight loss medications (for example, Contrave, Wegovy, Qsymia, Xenical, Saxenda, Foundayo, previous Zepbound therapy, etc.)	**Dates of therapy**

7. Please provide the member's **baseline** (**BEFORE** therapy with Zepbound or any other current weight loss medication):

Height: _____ Weight: _____ Body Mass Index: _____

***Please attach documentation (for example, chart notes) to support above information.**

8. Only fill out this section for members currently on a weight loss medication.

- Which weight loss medication is the member currently taking? _____
- How long has the member been on this medication?_____
- Please provide the member's **current** (while on therapy with Zepbound or other weight loss medication):

Height: _____ Weight: _____ Body Mass Index: _____

***Please attach documentation (for example, chart notes) to support above information.**

9. Is the member using Zepbound with another glucagon-like peptide-1 receptor agonist or glucagon-like peptide-1 receptor agonist combinations (for example, with insulin, glucagon-like peptide-1 receptor agonist)?

☐ **Yes** ☐ **No**

10. Is Zepbound being used for the treatment of obstructive sleep apnea?

☐ **Yes** ☐ **No**

If **YES**, please answer the remaining questions in this section:

a. Is Zepbound being prescribed by or in consultation with a sleep specialist?

☐ **Yes** ☐ **No**

b. An AHI (apnea/hypopnea index), RDI (respiratory disturbance index), or REI (respiratory event index) score is used to assess the severity of sleep apnea.

AHI, RDI, or REI should be obtained from a diagnostic polysomnography, recording time, or home sleep apnea test, WITHOUT the use of positive airway pressure or oral appliance during testing.

Please provide the baseline (**BEFORE** therapy with Zepbound) AHI, RDI, or REI:

Apnea/hypopnea index (AHI): _____ events per hour

Respiratory disturbance index (RDI): _____ events per hour

Respiratory event index (REI): _____ events per hour

***Please attach baseline diagnostic polysomnography, recording time, or home sleep apnea test to support this information.**

c. Does the member have a baseline AHI, RDI, or REI at the time of the request (for example, within 3-6 months)?

☐ **Yes** ☐ **No**

d. Baseline AHI or RDI should also be obtained **WITH** the use of positive airway pressure or oral appliance during testing.

Please provide the baseline (**BEFORE** therapy with Zepbound) AHI and RDI after optimization of guideline directed care (use of positive airway pressure or oral appliance during testing):

Apnea/hypopnea index (AHI): _____ events per hour

Respiratory disturbance index (RDI): _____ events per hour

Respiratory event index (REI): _____ events per hour

***Please attach baseline sleep study or device report to support this information.**

e. Is the member currently receiving and compliant with positive airway pressure (specifically, the device was used for 70 percent of nights for four or more hours per night, for two or more months)?

☐ **Yes** ☐ **No**

If yes, please attach documentation of a device report to support this information.

f. Has the member experienced therapeutic failure, intolerance, or contraindication to positive airway pressure?

☐ **Yes** ☐ **No**

g. Is the member using a custom, titratable, oral appliance?

☐ **Yes** ☐ **No**

If YES:

Is the oral appliance prescribed by or in consultation with a sleep specialist?

☐ **Yes** ☐ **No**

Has the member been adherent to the oral appliance?

☐ **Yes** ☐ **No**

h. Has the member practiced sleep hygiene modifications (for example, sleep positioning to avoid a supine position, avoidance of alcohol and sedatives before bed) for at least six months prior to initiation of Zepbound?

☐ **Yes** ☐ **No**

If yes, please attach documentation (specifically, chart notes) to support this information.

i. Is the member using Zepbound in combination with sleep hygiene modifications (for example, sleep positioning to avoid a supine position, avoidance of alcohol and sedatives before bed)?

☐ **Yes** ☐ **No**

***If YES, please attach documentation (specifically, chart notes) to support this information.**

j. Is the member currently established on therapy with Zepbound for obstructive sleep apnea?

☐ **Yes** ☐ **No**

If **YES**:

i. Please specify how long the member has been on therapy with Zepbound: _____

ii. Current AHI, RDI, or REI (**AFTER** therapy with Zepbound) should be obtained **WITH** the use of positive airway pressure or oral appliance during testing.

Please provide the current AHI, RDI, or REI after optimization of guideline directed care (use of positive airway pressure or oral appliance during testing):

Apnea/hypopnea index (AHI): _____ events per hour

Respiratory disturbance index (RDI): _____ events per hour

Respiratory event index (REI): _____ events per hour

***Please attach documentation (positive airway pressure device report, sleep study, or home sleep apnea test) to support this information.**

iii. Does the member require additional therapy with Zepbound?

☐ **Yes** ☐ **No**

11. Please provide any other medications that the member has tried and failed:

_____

_____

_____

The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the member. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.

2. Please print, type or write legibly in blue or black ink.
3. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
4. Please provide the physician address as it is required for physician notification.
5. Fax the **completed** form and all clinical documentation to **1-866-240-8123**
   Or mail the form to: **120 Fifth Avenue, SPECARE, Pittsburgh, PA 15222**

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