TRICARE Prior Authorization Request Form for
liraglutide 3 mg injection **(Saxenda),** semaglutide 2.4mg injection **(Wegovy)**
tirzepatide injection **(Zepbound)**

JOHNS HOPKINS
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Initial therapy approves for 6 months, renewal approves for 12 months. For renewal of therapy an initial Tricare prior authorization approval is required.

Step 1 **Please complete patient and physician information** (please print):

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.*	☐ Yes (subject to verification) Proceed to question **15**	☐ No **Proceed to question 2**
2. How old is the patient?	☐ Less than 12 years of age - **STOP Coverage not approved** ☐ Greater than or equal to 12 years of age and less than 18 years of age - Proceed to question **3** ☐ Greater than or equal to 18 years of age - Proceed to question **6**	
3. Does the patient have BMI GREATER THAN OR EQUAL TO the 95th percentile standardized for age and sex?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Has the patient tried and failed or has a contraindication to Qsymia or its individual generic components?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**

5. Please provide the date and duration or contraindication for each medication listed below.

Note: The dates and durations of therapy for each medication or contraindication to each medication listed below must be provided or your case could be denied.

Qsymia: Date_____ **Duration of therapy** _____ **Contraindication** _____

Proceed to question **9**

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6. Does the patient have BMI GREATER THAN or EQUAL to 30, or a BMI GREATER THAN or EQUAL to 27 for those with risk factors in addition to obesity (diabetes, impaired glucose tolerance, dyslipidemia, hypertension, sleep apnea)?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Has the patient tried and failed or has a contraindication to phentermine, Qsymia or its individual generic components, and Contrave or its individual generic components?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

8. Please provide the date and duration or contraindication for each medication listed below.

Note: The dates and durations of therapy for each medication or contraindication to each medication listed below must be provided or your case could be denied.

Phentermine: Date_____ Duration of therapy _____ Contraindication _____

Qsymia or its individual generic components - topiramate and phentermine:

Date _____ Duration of therapy _____ Contraindication _____

Contrave or its individual generic components - bupropion and naltrexone:

Date _____ Duration of therapy _____ Contraindication _____

Proceed to question **9**

9. Does the patient have type 2 diabetes?	☐ Yes Proceed to question **10**	☐ No Proceed to question **11**
10. Has the patient tried and failed metformin and the preferred GLP1-RAs (Trulicity)?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Will the requested medication be used with another GLP1RA (for example, Bydureon, Trulicity, Byetta, Adlyxin, Victoza, Soliqua, Xultophy)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. Does the patient have a history of or family history of medullary thyroid cancer, or multiple endocrine neoplasia syndrome type 2?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 13**
13. Has the patient engaged in a trial of 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?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

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15. Is the patient currently engaged in behavioral modification and on a reduced calorie diet?	☐ Yes Proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. How old is the patient?	☐ Less than 12 years of age - **STOP Coverage not approved** ☐ Greater than or equal to 12 years of age and less than 18 years of age - Proceed to question **18** ☐ Greater than or equal to 18 years of age - Proceed to question **17**	
17. Has the patient lost GREATER THAN or EQUAL to 4 percent of baseline body weight since starting medication despite 16 weeks of therapy?	☐ Yes Proceed to question **19**	☐ No **STOP** **Coverage not approved**
18. Has the patient experienced a reduction of AT LEAST 5 percent of baseline BMI?	☐ Yes Proceed to question **19**	☐ No **STOP** **Coverage not approved**
19. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

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

Prescriber Signature _____ Date _____

[10 Jan 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: