Nebraska Medicaid Program
Request for Prior Authorization
Anti-Obesity Medication
Fax this form to 866-759-4115.

Note: If the prior authorization request is approved, payment is still subject to all general requirements, including current member eligibility, other insurance, and other program restrictions.

MEMBER INFORMATION

*Member Last Name: _____

*Member First Name: _____

*Medicaid ID: _____

*Date of Birth: _____ Age: _____

PRESCRIBER INFORMATION

* Prescriber Last Name: _____

* Prescriber First Name: _____

* Prescriber NPI: _____ NE Medicaid Provider ID: _____

Physician Address: _____

City: _____ State: _____ ZIP: _____

E-mail Address: _____

* Prescriber Phone: _____ * Prescriber Fax: _____

DISPENSING PHARMACY INFORMATION

Pharmacy Name: _____

* Pharmacy NPI: _____ NE Medicaid Provider ID: _____

Pharmacy Address: _____

City: _____ State: _____ ZIP: _____

E-mail Address: _____

* Pharmacy Phone: _____ * Pharmacy Fax: _____

***Required Fields**

Member's Name: _____

DRUG REQUESTED

Tirzepatide (Zepbound) is only covered for the treatment of moderate-to-severe obstructive sleep apnea (OSA) in adults aged at least 18 years.

* NDC: _____ Dosing: _____

INITIAL REQUEST CRITERIA

Initial authorization period is 6 months.

1. Does the member have a diagnosis of diabetes?

   ☐ Yes ☐ No

2. Does the member currently have a HgA1c of at least 6.5 percent?

   ☐ Yes ☐ No

3. Does the member have an initial BMI of at least 30 kg/m^2?

   ☐ Yes ☐ No

4. Has the member completed a weight management program medically supervised by a physician, nurse practitioner, or a physician assistant and counseling for at least 6 months that includes **all** the following?

   - Behavior modification, and
   - Reduced calorie diet, and
   - Increased physical activity, and
   - Counseling to avoid sleeping in the supine position, and
   - Counseling to avoid alcohol and sedatives before bedtime

   ☐ Yes ☐ No

5. a) Has the member previously or is the member **currently** being treated with positive airway pressure (PAP) treatment?

   ☐ Yes ☐ No

   b) Has the member demonstrated any of the following?
   Supporting documentation must be submitted. Choose all that apply:

   ☐ Failure to achieve therapeutic goals despite optimization of PAP treatment, or

   ☐ Intolerance to PAP treatment, or

   ☐ Is not a candidate for PAP treatment

Member's Name: _____

6. a) Has the member previously or is the member currently being treated with oral appliance treatment?

   ☐ Yes ☐ No

   b) Has the member demonstrated any of the following?
   Supporting documentation must be submitted. Choose all that apply:

   ☐ Failure to achieve therapeutic goals despite optimization of oral appliance treatment, or

   ☐ Intolerance to oral appliance treatment, or

   ☐ Is not a candidate for oral appliance treatment

7. Does the member have moderate to severe OSA with polysomnography (PSG) evidence of one of the following?
   Supporting documentation must be submitted. Choose one of the following:

   ☐ Apnea-hypopnea index (AHI) of at least 15

   ☐ Respiratory Disturbance Index (RDI) of at least 15

   ☐ Respiratory Event Index (REI) of at least 15

8. Is tirzepatide (Zepbound) being prescribed by, or in consultation with, a sleep specialist?

   ☐ Yes ☐ No

   If a sleep specialist was consulted, please provide the name of the specialist:

   _____

9. Does the member have any of the following?
   Choose all that apply:

   ☐ Planned surgery for sleep apnea or obesity

   ☐ Significant craniofacial abnormalities

   ☐ A diagnosis of central or mixed sleep apnea

10. Is the member currently on and will continue to follow **all** the following?

    - Behavior modification, and
    - Reduced calorie diet, and
    - Increased physical activity, and
    - Compliance with sleep positioning, and
    - Compliance with no alcohol or sedatives before bedtime, and
    - Adherence to the prescribed PAP treatment (defined as at least 4 hours of use per night for at least 70 percent of nights for 2 or more months) or oral appliance treatment as applicable

    ☐ Yes ☐ No

Member's Name: _____

11. Does the member have any of the following?
    Choose all that apply:

    ☐ NYHA Class IV Heart failure

    ☐ Impaired renal function (eGFR < 30 mL/min/1.73m2)

    ☐ History of chronic pancreatitis or presence of acute or chronic pancreatitis

    ☐ Personal or first-degree relative(s) history of multiple endocrine neoplasia type 2 or medullary thyroid carcinoma

    ☐ Known or suspected hypersensitivity to the requested product

    ☐ History of suicidal attempts or active suicidal ideation

    ☐ Female who is pregnant, breastfeeding, or intends to become pregnant, or is of childbearing potential and not using a highly effective contraceptive method

12. Will the member be using the requested product in combination with other tirzepatide-containing products, any other GLP-1 receptor agonists, or DPP-4 inhibitors?

    ☐ Yes ☐ No

13. The provider agrees to the treatment plan of initiation and escalation of dosages up to a maximum of 20 weeks up to the recommended maintenance dose of 10 mg or 15 mg once weekly.

    ☐ Yes ☐ No

RENEWAL REQUEST CRITERIA

Duration of approval:

- 6 months for members who have been on tirzepatide (Zepbound) therapy for fewer than 52 weeks of consecutive therapy
- 12 months for members who have been on tirzepatide (Zepbound) therapy for at least 52 weeks of consecutive therapy

1. Has the member completed at least 52 weeks of consecutive therapy with the requested product at a stable maintenance dose?

    ☐ Yes ☐ No

2. Has the member completed titration and is now at a stable maintenance dose of 10 mg or 15 mg once weekly?

    ☐ Yes ☐ No

Member's Name: _____

3. Is the member continuing to follow all the following?
    - Behavioral modification, and
    - A reduced calorie diet, and
    - Increased physical activity, and
    - Compliance with sleep positioning, and
    - Compliance with no alcohol or sedatives before bedtime, and
    - Adherence to the prescribed PAP treatment (defined as at least 4 hours of use per night for at least 70 percent of nights for 2 or more months) or oral appliance treatment as applicable

    ☐ Yes ☐ No

    If No, please describe why not:

    _____

4. Does the member have a diagnosis of diabetes?

    ☐ Yes ☐ No

5. Does the member currently have a HgA1c at least 6.5 percent?

    ☐ Yes ☐ No

6. Does the member continue to require tirzepatide (Zepbound) treatment for moderate to severe OSA?

    ☐ Yes ☐ No

7. Does the member have a positive clinical response to tirzepatide (Zepbound) therapy evidenced by a decrease from baseline in one of the following? Choose one of the following:

    ☐ Apnea-hypopnea index (AHI)

    ☐ Respiratory Disturbance Index (RDI)

    ☐ Respiratory Event Index (REI)

8. Is tirzepatide (Zepbound) being prescribed by, or in consultation with, a sleep specialist?

    ☐ Yes ☐ No

    If a sleep specialist was consulted, please provide the name of the specialist:

    _____

9. Will the member be using the requested product in combination with other tirzepatide-containing products, any other GLP-1 receptor agonists, or DPP-4 inhibitors?

    ☐ Yes ☐ No

Member's Name: _____

10. Does the member have any of the following? Choose all that apply:

- ☐ NYHA Class IV Heart failure
- ☐ Impaired renal function (eGFR < 30 mL/min/1.73m2)
- ☐ History of chronic pancreatitis or presence of acute or chronic pancreatitis
- ☐ Personal or first-degree relative(s) history of multiple endocrine neoplasia type 2 or medullary thyroid carcinoma
- ☐ Known or suspected hypersensitivity to the requested product
- ☐ History of suicidal attempts or active suicidal ideation
- ☐ Female who is pregnant, breastfeeding, or intends to become pregnant, or is of childbearing potential and not using a highly effective contraceptive method

PRESCRIBING PRACTITIONER SIGNATURE

With this signature, the prescriber confirms that the information submitted above is accurate and verifiable in the member's medical records.

Note: The Department may request medical records to verify the information submitted above.

Prescriber Printed Name: _____

Prescriber Signature: _____ **Date:** _____

(Signature of anyone else is **not** acceptable.)

(With this signature, the prescriber confirms that the information above is accurate and verifiable in member records.)

Submit requests to:
Prime Therapeutics State Government Solutions, LLC
Fax: 866-759-4115
Telephone: 800-241-8335