

AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-305-671-0200.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Group Specific Benefit

Drug Requested: Zepbound® (tirzepatide) for Obstructive Sleep Apnea (OSA)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

Recommended Dosage for Obstructive Sleep Apnea:

- Starting dosage of Zepbound for all indications is 2.5 mg injected SC once weekly for 4 weeks.
 - The maintenance dosage for OSA is 10 mg or 15 mg injected SC once weekly
 - The maintenance dosage for weight reduction is 5 mg, 10 mg, or 15 mg, injected SC once weekly

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 7 months

☐ Member is 18 years of age or older

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- ☐ Member must have a confirmed diagnosis of moderate to severe obstructive sleep apnea (OSA) based on **ALL** the following (**submit documentation**):
 - ☐ Polysomnography (PSG) or Home Sleep Apnea Test (HSAT) with medical device (e.g., CPAP)
 - ☐ An Apnea-Hypopnea Index (AHI) ≥ 15 events per hour
The American Academy of Sleep Medicine (AASM Soring Manual, 2023) classifies the OSA severity level (based on AHI) as the following:
 - **Mild Sleep Apnea:** 5-14 events/hour
 - **Moderate Sleep Apnea:** 15-29 events/hour
 - **Severe Sleep Apnea:** 30 + events/hours
 - ☐ Provider must submit member's current baseline (pre-treatment) AHI measurement from a polysomnography
AHI (in events per hour): _____ **Date:** _____
 - ☐ Member must exhibit symptoms consistent with OSA, such as excessive daytime sleepiness, loud snoring, choking, gasping, difficulty maintaining sleep throughout the night or impairment in daily functioning related to OSA
- ☐ Member must have a body mass index (BMI) of 30 kg/m² or greater
- ☐ Provider must submit member's current baseline (pre-treatment) BMI measurements:
Height: _____ **Weight:** _____ **BMI:** _____ **Date:** _____
- ☐ Member must use requested medication in combination with a weight loss treatment plan (e.g., nutritional counseling, an exercise regimen, and/or a calorie/fat-restricted diet)
- ☐ Provider attests the member does **NOT** have any of the following:
 - Central sleep apnea with percent of central apneas/hypopneas $\geq 50\%$
 - Cheyne Stokes respiration
- ☐ Member will **NOT** use concurrent therapy with another GLP-1 receptor agonist prescribed for another indication (e.g., Mounjaro[®], Ozempic[®], Trulicity[®], Rybelsus[®])
- ☐ Provider attests the member will be appropriately titrated to a maximum tolerated maintenance dose of 10 mg or 15 mg once weekly

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ☐ Member must continue to meet **ALL** the following:
 - ☐ Member has an established diagnosis of moderate to severe obstructive sleep apnea and obesity
 - ☐ Member has achieved & maintained at least a 10% decrease from their baseline bodyweight
 - ☐ Provider must submit baseline (pre-treatment) BMI measurements:
Height: _____ **Weight:** _____ **BMI:** _____ **Date:** _____

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- ☐ Provider must submit current BMI measurements:

Height: _____ **Weight:** _____ **BMI:** _____ **Date:** _____

- ☐ Member must continue using requested medication in combination with a weight loss treatment plan (e.g., nutritional counseling, an exercise regimen, and/or a calorie/fat-restricted diet)
- ☐ Member has improvements in symptoms of OSA such as excessive daytime sleepiness, loud snoring, choking, gasping, or difficulty maintaining sleep resulting in better concentration or alertness and/or reduced fatigue, reflecting improvement in quality of life
- ☐ Provider attests the member does **NOT** have any of the following:
- Central sleep apnea with percent of central apneas/hypopneas $\geq 50\%$
 - Cheyne Stokes respiration
- ☐ Member is being treated with a maximum tolerated maintenance dose of 10 mg or 15 mg once weekly

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****