TRICARE Prior Authorization Request Form for
semaglutide injection/tablets **(Wegovy),** tirzepatide injection (**Zepbound Pen Injector**)

6311

PLEASE NOTE: Zepbound is covered for a maximum quantity of 30 day supply at retail and up to a 60 day supply at the Martin's Point Mail Order Pharmacy. Wegovy is covered for a maximum quantity of 30 day supply at retail and up to a 60 day supply at the Martin's Point Mail Order Pharmacy. Your patient will save on copays by using the Martin's Point Mail Order Pharmacy. Thank you.

Martin's Point

Clinical Documentation is required for a determination to be made.

Please fax completed form back to: (207) 828-7816

Initial therapy approves for 12 months; annual renewal is required. For renewal of therapy an initial Tricare prior authorization approval is required. Note: Non-FDA approved uses are not approved including diabetes mellitus.

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. Under penalties for false claims against the United States government, I declare that I have examined the patient, and the statements made are true, correct, and complete to the best of my professional knowledge	☐ **Acknowledged** Proceed to Question 2	
2. Is the prescriber an MTF or TRICARE Network provider who has billed TRICARE for professional services provided to assess the patient and develop a treatment plan?	☐ Yes (subject to verification) Proceed to question **3**	☐ No **STOP – Coverage not approved**
3. Weight loss medications must be prescribed by a TRICARE-authorized provider. Please provide up to date provider and office information:	Group/Office NPI: Group/Office TIN:	
4. 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 **29**	☐ No Proceed to question **5**
5. What is the indication or diagnosis?*	☐ Weight management - Proceed to question **6** ☐ Moderate to severe obstructive sleep apnea (OSA) in adults with obesity - Proceed to question **21** ☐ Other diagnosis - **STOP - Coverage not approved**	

***If patient is diabetic and meets the prior authorization criteria for Trulicity, Victoza, Ozempic, or Mounjaro, please consider these alternatives.**

6. 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 **7** ☐ 18 years of age or older - Proceed to question **10**	
7. What is the requested medication?	☐ Wegovy Injection Proceed to question **8**	☐ Zepbound Pen Injector or Wegovy Tablets **STOP** **Coverage not approved**
8. Does the patient have a BMI GREATER THAN OR EQUAL TO the 95th percentile standardized for age and sex?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. The provider affirms that the patient has been engaged in behavioral modification and dietary restriction for at least 6 months and has failed to achieve the desired weight loss, will remain engaged throughout course of therapy, AND the provider has documented this in the medical record.	☐ Yes (subject to verification) Proceed to question **26**	☐ No **STOP** **Coverage not approved**
10. What is the patient's body mass index (BMI)?	☐ Less Than 27 – **STOP - Coverage not approved** ☐ 27 to 29 with an additional comorbidity - Proceed to question **11** ☐ 30 to 34 - Proceed to question **13** ☐ 35 to 39 – Proceed to question **13** ☐ 40 or GREATER - Proceed to question **13**	
11. Does the patient have AT LEAST ONE weight-related comorbidity?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. In addition to overweight with BMI GREATER THAN 27, what are the major condition(s)/comorbidities being treated (select all that apply)?	☐ Diabetes or impaired glucose tolerance ☐ Obstructive sleep apnea ☐ Osteoarthritis ☐ Metabolic syndrome ☐ Dyslipidemia ☐ Hypertension ☐ Metabolic dysfunction-associated steatohepatitis (MASH) ☐ Established cardiovascular disease with a history of stroke ☐ Established cardiovascular disease with a history of myocardial infarction ☐ Established cardiovascular disease with a history of peripheral artery disease Proceed to question **14**	

13. What are the major condition(s)/comorbidities being treated (select all that apply)?	☐ Obesity ☐ Diabetes or impaired glucose tolerance ☐ Obstructive sleep apnea ☐ Osteoarthritis ☐ Metabolic syndrome ☐ Dyslipidemia ☐ Hypertension ☐ Metabolic dysfunction-associated steatohepatitis (MASH) ☐ Established cardiovascular disease with a history of stroke ☐ Established cardiovascular disease with a history of myocardial infarction ☐ Established cardiovascular disease with a history of peripheral artery disease Proceed to question **14**	
14. The provider affirms that the patient has been engaged in behavioral modification and dietary restriction for at least 6 months and has failed to achieve the desired weight loss, will remain engaged throughout course of therapy, AND the provider has documented this in the medical record.	☐ Yes (subject to verification) Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Has the patient tried 3 months of generic phentermine, benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR and failed to achieve a 5% reduction in baseline weight?	☐ Yes Proceed to question **16**	☐ No Proceed to question **19**
16. Please provide drug name. **Phentermine, benzphetamine, diethylpropion (IR/SR), or phendimetrazine (IR/SR).** **Drug name**_____ Proceed to question **17**		
17. Please provide the date of therapy. **Date**_____ Proceed to question **18**		
18. Please provide the duration of therapy. **Duration of therapy** _____ Proceed to question **26**		
19. Does the patient have a contraindication to generic phentermine, benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR (for example, arrhythmias, coronary artery disease, heart failure, stroke, uncontrolled hypertension, etc.)?	☐ Yes List contraindication: Proceed to question 26	☐ No Proceed to question **20**
20. Has the patient experienced an adverse reaction to phentermine, benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR that is not expected to occur with the requested medication?	☐ Yes List adverse reaction: Proceed to question 26	☐ No **STOP** **Coverage not approved**

21. What is the requested medication?	☐ Wegovy **STOP** **Coverage not approved**	☐ Zepbound Pen Injector Proceed to question **22**
22. Is the patient 18 years of age or older?	☐ Yes Proceed to question **23**	☐ No **STOP** **Coverage not approved**
23. Does the patient have moderate to severe OSA (documented apnea-hypopnea index GREATER THAN OR EQUAL TO 15 events per hour)?	☐ Yes Proceed to question **24**	☐ No **STOP** **Coverage not approved**
24. Does the patient have a BMI greater than or equal to 30?	☐ Yes Proceed to question **25**	☐ No **STOP** **Coverage not approved**
25. The provider affirms that the patient has been engaged in behavioral modification and dietary restriction for at least 6 months and has failed to achieve the desired weight loss, will remain engaged throughout course of therapy, AND the provider has documented this in the medical record.	☐ Yes (Subject to verification) Proceed to question **26**	☐ No **STOP** **Coverage not approved**
26. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **27**
27. Will the requested medication be used with another GLP1RA (for example, Trulicity, Victoza, Soliqua, Xultophy)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **28**
28. 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 **Sign and date below**
29. What is the indication or diagnosis?	☐ Weight management - Proceed to question **30** ☐ Moderate to severe obstructive sleep apnea (OSA) in adults with obesity - Proceed to question **36** ☐ Other diagnosis - **STOP - Coverage not approved**	
30. The provider affirms that the patient is currently engaged in behavioral modification, on a reduced calorie diet, AND the provider continues to maintain documentation in the medical record.	☐ Yes (subject to verification) Proceed to question **31**	☐ No **STOP** **Coverage not approved**
31. 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 **32** ☐ 18 years of age or older - Proceed to question **34**	

32. What is the requested medication?	☐ Wegovy Injection Proceed to question **33**	☐ Zepbound Pen Injector or Wegovy Tablet **STOP** **Coverage not approved**
33. Has the patient lost GREATER THAN or EQUAL to 4 percent of baseline body weight since starting medication with full dosage titration?	☐ Yes - **Sign and date below** ☐ No – **STOP - Coverage not approved** ☐ The patient has had an interruption of therapy and is restarting therapy **– please submit this request using the initial therapy pathway -** Proceed to question **5**	
34. What is the patient's current body mass index (BMI)?	☐ Less Than 27 – Proceed to question **35** ☐ 27 to 29 - Proceed to question **35** ☐ 30 to 34 - Proceed to question **35** ☐ 35 to 39 – Proceed to question **35** ☐ 40 or GREATER - Proceed to question **35**	
35. Has the patient lost GREATER THAN or EQUAL to 5 percent of baseline body weight since starting medication with full dosage titration?	☐ Yes - **Sign and date below** ☐ No – **STOP - Coverage not approved** ☐ The patient has had an interruption of therapy and is restarting therapy **– please submit this request using the initial therapy pathway -** Proceed to question **5**	
36. What is the requested medication?	☐ Wegovy **STOP** **Coverage not approved**	☐ Zepbound Pen Injector Proceed to question **37**
37. Has the patient shown improvement in OSA symptoms based on the improvement of apnea hypopnea index?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

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

Prescriber Signature _____ Date _____

[12 March 2026]

Please attach office notes (clinical documentation)

Martin's Point

US FAMILY HEALTH PLAN

Quick Reference Guide for GLP-1s and Weight Loss Agents

covered by the Martin's Point US Family Health Plan

-All GLP-1s and weight loss agents require prior authorization. PAs are renewed yearly.
-Weight loss agents are required to be prescribed by a TRICARE Network provider.
-For weight loss agents, patients are considered new users if they haven't filled the medication under TRICARE benefit in the past 6 months (must have previously approved PA). If switched TRICARE plans, please submit previous TRICARE PA approval letter.
-The Martin's Point Mail Order Pharmacy is preferred for US Family Health Plan members. Your patient will receive a larger supply at a lower cost. Please send the rx to our mail order.

GLP-1s

-For type II DM, it is preferred for a GLP-1 FDA-approved for type II DM be prescribed if meet the PA criteria.
-For prediabetes, type 1 DM, and weight loss without type II DM, GLP-1s FDA-approved for type II DM are not coverable. If prescribing for weight loss, prescribe a GLP-1 FDA-approved for weight loss.

For patients with type II DM

GLP-1	Prior Authorization Criteria
Trulicity® (Tier 2)***preferred*** **Mounjaro®** (Tier 3) **Ozempic®** (Tier 3)	1. Type II DM AND 2. Trial with **metformin** or evidence of contraindication
Exenatide (Tier 3) **Liraglutide/Victoza®** (Tier 3)	1. Type II DM AND 2. Trial with **metformin** or evidence of contraindication AND 3. Trial with **Trulicity and Ozempic**

For weight loss

GLP-1	BMI & required trials
Wegovy® (Tier 2)	12-17 yrs of age 1. BMI ≥95th percentile standardized for age and sex ≥18 yrs of age 2. BMI ≥30 or 27-29 in the presence of at least one weight-related comorbidity 3. 12 week course of **phentermine, benzphetamine, diethylpropion IR/SR or phendimetrazine IR/SR** or evidence of adverse reaction or contraindication
Zepbound™ (Tier 2) *Also can be approved for sleep apnea	Weight loss 1. ≥18 yrs of age 2. BMI ≥30 or 27-29 in the presence of at least one weight-related comorbidity 3. 12 week course of **phentermine, benzphetamine, diethylpropion IR/SR or phendimetrazine IR/SR** or evidence of adverse reaction or contraindication Moderate to severe obstructive sleep apnea 1. ≥18 yrs of age 2. Documented apnea-hypopnea index ≥15 events/hr 3. BMI ≥30

Liraglutide/Saxenda® (Tier 3)	12-17 yrs of age 1. BMI ≥95th percentile standardized for age and sex 2. Trial with **phentermine/topiramate ER (Qsymia) AND Wegovy** or evidence of contraindication ≥18 yrs of age 1. BMI ≥30 or 27-29 in the presence of at least one weight-related comorbidity 2. Trial with or evidence of contraindication to **ALL** of the following: 1. **phentermine, benzphetamine, diethylpropion IR/SR or phendimetrazine IR/SR** 2. **phentermine/topiramate ER (Qsymia)** 3. **Contrave** 4. **Wegovy AND Zepbound**

Other Weight Loss Agents

Drug Names	BMI and required trials
Generic phentermine (Tier 1) **Benzphetamine** (Tier 1) **Diethylpropion IR/SR** (Tier 1) **Phendimetrazine IR/SR** (Tier 1) **Lomaira**® (Tier 2)	1. BMI 27-29 with evidence of at least one weight-related comorbidity OR 2. BMI ≥30
phentermine/topiramate ER (Tier 1) **Brand Qsymia**® (Tier 2) *requires brand name PA	12-17 yrs of age 1. BMI ≥95th percentile standardized for age and sex ≥18 yrs of age 1. BMI ≥30 or 27-29 in the presence of at least one weight-related comorbidity 2. 12 week course of phentermine, benzphetamine, diethylpropion IR/SR or phendimetrazine IR/SR or evidence of adverse reaction or contraindication
Contrave® (Tier 2) (naltrexone SR/bupropion SR)	1. ≥18 yrs of age 2. BMI ≥30 or 27-29 in the presence of at least one weight-related comorbidity 3. 12 week course of **phentermine, benzphetamine, diethylpropion IR/SR or phendimetrazine IR/SR** or evidence of adverse reaction or contraindication
Orlistat/Xenical® (Tier 3)	12-17 yrs of age 3. BMI ≥95th percentile standardized for age and sex or BMI 85-94th percentile with at least one severe comorbidity 4. Trial with **phentermine/topiramate ER (Qsymia) AND Wegovy** or evidence of contraindication ≥18 yrs of age 3. BMI ≥30 or 27-29 in the presence of at least one weight-related comorbidity 4. Trial with or evidence of contraindication to **ALL** of the following: 1. **phentermine, benzphetamine, diethylpropion IR/SR or phendimetrazine IR/SR** 2. **phentermine/topiramate ER (Qsymia)** 3. **Contrave** 4. **Wegovy AND Zepbound**

*This chart is intended for internal use only by providers for guidance about covered weight-loss medications.

Martin's Point

US FAMILY HEALTH PLAN

Supporting Documentation Requirements

- Include the following evidence of patient engagement, progress, and prior treatment history for approval consideration to Martin's Point Pharmacy Administration at **207-828-7816**

Documented Participation in Behavioral and Dietary Program ≥6 Months

showing the patient has been actively engaged in a structured weight loss program
Acceptable documentation may include:

Progress notes, chart documentation and/or history of claims from:

- A registered dietitian, physician or nurse practitioner
- A structured weight loss clinic or program (e.g., Weight Watchers, Noom, medical weight management)

Evidence of via chart documentation and/or history of claims from:

- Nutritional counseling
- Behavioral interventions (goal setting, self-monitoring, stress management)
- Physical activity counseling

Weight loss program summaries

- Logs from nutrition apps (e.g., MyFitnessPal)
- Progress tracking charts

Documentation Confirming Height, Weight and BMI

- Show evidence that the patient did not meet target weight loss goals, despite 6+ months of effort.
  - Starting weight and BMI **AND**
  - Ending weight and BMI

Continued Engagement Commitment

- Document the patient's intent and ability to remain engaged during the full course of medication therapy.
- This can include a provider note, signed patient agreement, or Referrals to continued behavioral support or follow-up visit

Information about Receiving Phentermine in the past

- Include Starting Weight and ending Weight in chart notes

Please call our Pharmacy Administration Department with any questions at 207-274-2789.

Thank you.
Martin's Point US Family Health Plan Pharmacy Administration

When sending documentation, the provider understands under penalties for false claims against the United States government, I declare that I have examined the patient, and the statements made are true, correct, and complete to the best of my professional knowledge.