TRICARE Prior Authorization Request Form for
semaglutide injection (Ozempic), tirzepatide injection (Mounjaro)

6740

To be completed and signed by the prescriber.

Martin's Point

Clinical Documentation is required for a determination to be made.

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

Prior authorization does not expire.

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. What is the diagnosis or indication?	☐ Type 2 diabetes mellitus - Proceed to question **2** ☐ Weight loss in patients who do not have diabetes - **STOP - Coverage not approved** ☐ Other – **STOP - Coverage not approved**	
2. Has the patient tried metformin (alone or in combination) and failed to achieve blood sugar control?	☐ Yes **Sign and date below**	☐ No Proceed to question **3**
3. Has the patient experienced a history of lactic acidosis?	☐ Yes **Sign and date below**	☐ No Proceed to question **4**
4. Does the patient have a contraindication to metformin (for example, impaired renal function)?	☐ 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 _____

[02 September 2026]

Please attach office notes (clinical documentation)