# SENTARA HEALTH PLANS

## 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 1-800-750-9692**. 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 Sentara #:** _____ **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 ≥ 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 ≥ 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.****



***Approved by Pharmacy and Therapeutics Committee**: 1/23/2025
**REVISED/UPDATED/REFORMATTED:** ~~1/28/2025; 4/18/2025; 7/1/2025;~~ 9/22/2025