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: 6 months

- ❑ Member is 18 years of age or older
- ❑ Prescribed by or in consultation with a provider specializing in sleep medicine, endocrinology, bariatrics, cardiology, or pulmonary disease

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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) conducted within the last 12 months
  - ❑ 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 Apne**a: 15-29 events/hour
    - **Severe Sleep Apnea**: 30 + events/hours
  - ❑ Provider must submit member's current baseline (pre-treatment) AHI measurement from a polysomnography **(verified by chart notes)**

    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 **(verified by chart notes)**
  - ❑ Provider must submit member's baseline Epworth Sleepiness Scale Score of ≥ 10 **(rating scale must be attached)**
- ❑ Member must have a body mass index (BMI) of 30 kg/m² or greater, with documentation of this BMI within the last 6 months **(verified by chart notes)**
- ❑ Provider must submit member's current baseline (pre-treatment) BMI measurements:

  Height: _____ Weight: _____ BMI: _____ Date: _____
- ❑ Member must have **ALL** the following **(verified by chart notes)**:
  - ❑ Member must have participated in a weight loss treatment plan (e.g., nutritional counseling, an exercise regimen, and/or a calorie/fat-restricted diet) in the past 6 months and will continue to follow this treatment plan while taking an anti-obesity medication
  - ❑ Member must have at least **ONE** obesity-related health complication (e.g., hypertension, dyslipidemia)
  - ❑ Member must have practiced sleep hygiene modifications (e.g., sleep positioning to avoid a non-supine position, avoidance of alcohol and sedatives before bed) in the past 6 months prior to initiation of Zepbound® therapy
- ❑ Member must have tried and failed, or is unable to tolerate, **ONE** of the following standard treatments for OSA **(verified by chart notes)**:
  - ❑ Continuous Positive Airway Pressure (CPAP):
    - ❑ Member has used CPAP therapy for ≥ 4 hours per night on ≥ 70% of nights, for two or more months despite proper education and support
    - ❑ Documentation of CPAP use must show persistent moderate to severe symptoms of OSA despite adherence to CPAP therapy
    - ❑ Alternatively, the member may have an intolerance to CPAP therapy (e.g., skin irritation, discomfort, or difficulty achieving therapeutic pressure), this must be documented

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- ❑ Bilevel Positive Airway Pressure (BiPAP) or Auto-Adjusting Airway Pressure (APAP) (if applicable):
  - ❑ Member has complex or severe OSA, including individuals who cannot tolerate CPAP therapy
  - ❑ Member has used (BiPAP) or (APAP) therapy for ≥ 4 hours per night on ≥ 70% of nights, for two or more months despite proper education and support
  - ❑ Documentation of (BiPAP) or (APAP) use must show persistent moderate to severe symptoms of OSA despite adherence to (BiPAP) or (APAP) therapy
  - ❑ Alternatively, the member may have an intolerance to (BiPAP) or (APAP) therapy (e.g., skin irritation, discomfort, or difficulty achieving therapeutic pressure), this must be documented

- ❑ Provider attests the member does **NOT** have any of the following:
  - A diagnosis of central or mixed sleep apnea
  - A diagnosis of obesity hypoventilation syndrome or daytime hypercapnia
  - Major craniofacial abnormalities
  - A planned procedure for sleep apnea or obesity
- ❑ 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: up to 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 **(submit documentation; verified by chart notes)**:
  - ❑ Member has an established diagnosis of moderate to severe obstructive sleep apnea and obesity
  - ❑ Member must meet **ONE** of the following **(verified by chart notes):**
    - ❑ Member has achieved at least a 10% decrease in their weight within the initial approval period of 6 months as documented by their physician **(Initial renewal length=6 months)**
      - ❑ Member has maintained initial 10% weight loss **(Subsequent renewal length=12 months)**
      - ❑ Provider must submit baseline (pre-treatment) BMI measurements:

        Height: _____ **Weight:** _____ **BMI:** _____ **Date:** _____
      - ❑ Provider must submit current BMI measurements:

        Height: _____ **Weight:** _____ **BMI:** _____ **Date:** _____
  - ❑ Member must continue with weight loss treatment plan (e.g., nutritional counseling, an exercise regimen and/or calorie/fat-restricted diet) while on medication for weight reduction

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- ❑ Member must meet **ONE** of the following **(verified by chart notes):**
  - ❑ Member has achieved an AHI reduction of ≥ 50% from baseline within the initial approval period of 6 months as documented by their physician **(Initial renewal length=6 months)**
  - ❑ Member has a reduction in AHI below 15 events per hour (if previously greater than 15), demonstrating clinical improvement in OSA severity **(Subsequent renewal length=12 months)**
  - ❑ Provider must submit baseline (pre-treatment) AHI measurements:

    AHI (in events per hour): _____ **Date:** _____
  - ❑ Provider must submit current AHI measurements:

    AHI (in events per hour): _____ **Date:** _____
- ❑ Member has improvements in symptoms of OSA such as excessive daytime sleepiness, loud snoring, choking, gasping, or difficulty maintain sleep.
- ❑ Provider has submitted an Epworth Sleepiness Scale Score to assess the reduction in daytime sleepiness, with a score reduction of at least 2-3 points from baseline demonstrating improvement **(rating scale must be attached)**
- ❑ Member has improvements in daily functioning, such as better concentration, alertness, and reduced fatigue, reflecting improvement in quality of life.
- ❑ Member must continue to practice sleep hygiene modifications (e.g., sleep positioning to avoid a non-supine position, avoidance of alcohol and sedatives before bed)
- ❑ Member is compliant with Zepbound® therapy since last approval **(verified by pharmacy paid claims)**
- ❑ Provider attests the member has **NOT** developed any negative side effects from Zepbound® therapy
- ❑ Provider attests the member does **NOT** have any of the following:
  - A diagnosis of central or mixed sleep apnea
  - A diagnosis of obesity hypoventilation syndrome or daytime hypercapnia
  - Major craniofacial abnormalities
  - A planned procedure for sleep apnea or obesity
- ❑ Provider attests the member does **NOT** have any medical or drug contraindications to Zepbound® therapy
- ❑ Member is being treated with a maximum tolerated maintenance dose of 10 mg or 15 mg once weekly **(verified by pharmacy paid claims)**

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**