

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.**

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** of 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 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 (**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 $\geq 70\%$ 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 $\geq 70\%$ 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 $\geq 50\%$ 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**)

*****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.****