South Dakota Department of Social Services

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Zepbound for OSA® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Moderate to severe obstructive sleep apnea (OSA)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Not covered for obesity or weight management or Type 2 diabetes mellitus

Clinical Information:

1. List the patient's BMI to one decimal place (i.e., 25.1, 36.8, etc) _____
2. Has the patient's OSA confirmed via sleep study? ❑ Yes ❑ No
   a. If yes, list the the respiratory events per hour result from the sleep study _____
3. Is the patient participating in a supervised weight management plan that encourages behavioral medication, reduced calorie diet, and increased physical activity? ❑ Yes ❑ No
4. Is the patient concomitantly using DPP-4 inhibitor therapy? ❑ Yes ❑ No
5. Is the patient using another GLP-1 receptor agonists? ❑ Yes ❑ No
6. Does the patient have personal or immediate family history of medullary thyroid carcinoma or multiple endocrine neoplasia type 2 (MEN2)? ❑ Yes ❑ No

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitatins?

❑ Titration or loading dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review? _____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.