Zepbound (tirzepatide) Obstructive Sleep Apnea Prior Authorization Form

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

West Virginia Medicaid
Bureau for Medical Services

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Fax: 1-800-531-7787
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Patient Name (Last) | (First) | (M) | WV Medicaid 11 Digit ID# | Date of Birth (MM/DD/YYYY)

Prescriber Name (Last) | (First) | (Credentials)

Prescriber Address (Street) | (City) | (State) | (Zip)

Prescriber 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

Pharmacy Name (if applicable)

Pharmacy Address (Street) | (City) | (State) | (Zip)

Pharmacy 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

Important Notes: Preauthorization for medical necessity does not guarantee payment.
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Drug Name

Zepbound (tirzepatide)

☐ Single-Dose Pen
☐ Multiple-Dose KwikPen
☐ Other _____

Strength | Duration (if applicable) | Route of Administration

Directions | Diagnosis | ICD Diagnosis Code (if available)

Please provide the patient's current (from within the last 90 days) height, weight, and BMI, and **attach the chart note from the visit the measurements were taken.**

Height (inches) | Weight (pounds) | BMI (kg/m^2) | Date Measured

Has the patient received counseling on chronic weight management (increased physical activity and a reduced calorie diet)? ☐ Yes ☐ No

Will the patient receive ongoing counseling on chronic weight management in combination with Zepbound if it is approved? ☐ Yes ☐ No

Initial Authorization

Has the patient had a polysomnogram or home sleep apnea test performed in the last 12 months? ☐ Yes ☐ No

If Yes, please document the apnea-hypopnea index (AHI) or respiratory event index (REI), document the date of the test, and **attach a copy of the test report.**

AHI or REI | Date of Test

Has the patient been counseled on the use of continuous positive airway pressure (CPAP) as a potential therapy? ☐ Yes ☐ No

Will the patient utilize Zepbound in combination with any other agent in the glucagon-like peptide-1 (GLP-1) or glucose-dependent insulinotropic peptide (GIP)/GLP-1 class? ☐ Yes ☐ No

If Yes, please document the GLP-1 or GIP/GLP-1 medication(s) that will be prescribed in combination with Zepbound.

Updated 3/14/2026

Initial Authorization (continued)

Does the patient also have a diagnosis of type 2 diabetes mellitus? ☐ Yes ☐ No

Please document the patient's most recent hemoglobin A1C lab result.

Hemoglobin A1C | Date of A1C

If the patient has a diagnosis of type 2 diabetes mellitus, please document any other GLP-1 or GIP/GLP-1 medications the patient has previously attempted. For each medication previously attempted, please provide the medication name, the dose (including titration details), the date range, and reason for discontinuing.

Continuation of Treatment

Please provide a brief description of the patient's response to therapy on Zepbound including:
- -Amount of weight loss achieved
- -Patient-reported improvement in daytime sleepiness
- -Partner-reported reduction in snoring episodes or pauses in breathing
- -Improvement in AHI or REI (if the patient has had a repeat polysomnogram or home sleep apnea test)

Please provide any other pertinent information you would like taken into consideration below.

Attestation: Your signature (manually or electronically) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.

☐ Check here for electronic signature

Prescriber or Pharmacist Signature | Date: (MM/DD/YYYY)