



**BlueCross
BlueShield**

Federal Employee Program

WEIGHT LOSS MEDICATIONS

PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn: Clinical Services
Fax: **1-877-378-4727**

Patient Information (required)				Provider Information (required)		
Date:				Provider Name:		
Patient Name:				Specialty:		NPI:
Date of Birth:	Sex: ☐ Male ☐ Female			Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:	State:	Zip:		City:	State:	Zip:
Patient ID:	R			Physician Signature:		
PHYSICIAN COMPLETES						

NOTE: Form must be completed in its **entirety** for processing

Please select medication below:

☐ **Saxenda (liraglutide)** quantity: _____ every 90 days ☐ **Wegovy (semaglutide)** quantity: _____ every 84 days

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ☐ Brand ☐ Generic

1. What is the patient's diagnosis?

- ☐ Chronic weight management ☐ Obesity, used for chronic weight management
☐ Elevated BMI, used for chronic weight management
☐ None of the above

2. Has the patient participated in a comprehensive weight management program such as Teladoc or another weight loss program? ☐ Yes ☐ No

3. Is the patient currently using another glucagon-like peptide-1 (GLP-1) receptor agonist? **Please select answer below.**

- ☐ **No, the patient is not using another GLP-1**
☐ **Yes, this is a change in therapy from another GLP-1 (specify medication):** _____
☐ **Yes, this is a request for an additional GLP-1 (specify medication):** _____

**GLP-1 Agonist Medications: Adlyxin (liraglutide), Bydureon/Bydureon BCise (exenatide), Byetta (exenatide), Mounjaro (tirzepatide), Ozempic (semaglutide), Rybelsus (semaglutide), Saxenda (liraglutide), Soliqua (liraglutide and insulin glargine), Trulicity (dulaglutide), Victoza (liraglutide), Wegovy (semaglutide), Xultophy (liraglutide and insulin degludec), Zepbound (tirzepatide)*

4. Will this medication be used in combination with another *Prior Authorization (PA) medication for weight loss? ☐ Yes* ☐ No

***If YES, please specify the medication:** _____

**PA Medications: Adipex-P, benzphetamine, Contrave (naltrexone/bupropion), diethylpropion, Imcivree (setmelanotide), Lomaira (phentermine), phendimetrazine, phentermine, Plenity (carboxymethylcellulose-cellulose-citric acid), Qsymia (phentermine/topiramate ER), Saxenda (liraglutide), Wegovy (semaglutide), Xenical (orlistat), Zepbound (tirzepatide)*

5. Has the patient been on this medication continuously for the last **4 months** excluding samples? **Please select answer below:**

☐ **NO** – this is **INITIATION** of therapy, please answer the following questions:

a. **Age 12-17:** What is the patient's body mass index (BMI) percentile for their age? **Please select answer below:**

☐ Less than 95th percentile ☒ **OR** ☐ Greater than or equal to 95th percentile

b. **Age 18 or older:** Please answer the following question:

i. What is the patient's body mass index (BMI) in kilograms per square meter (kg/m²)? **Please select answer below:**

☐ Less than 27 kg/m² ☐ Between 27 kg/m² and 29.9 kg/m² ☐ Greater than or equal to 30 kg/m²

ii. **If BMI is between 27 kg/m² and 29.9 kg/m²:** Does the patient have **ONE** of the listed weight related comorbid conditions **OR** established cardiovascular disease? **Please select answer below:**

- | | | |
|---|--|---|
| ☐ Type 2 diabetes mellitus | ☐ Cerebrovascular disease | ☐ Myocardial infarction (MI) |
| ☐ Dyslipidemia | ☐ Peripheral artery disease (PAD) | ☐ Unstable angina |
| ☐ Hypertension | ☐ Coronary heart disease | ☐ Coronary or other arterial revascularization |
| ☐ Congenital heart disease | ☐ Acute coronary syndrome (ACS) | ☐ Prior percutaneous coronary intervention/coronary bypass surgery |
| ☐ None of the above | | |

c. Is this medication being requested as a change from Zepbound to allow the member access to a reduced tier? ☐ Yes ☐ No

☐ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

a. **Age 12-17:** Has the patient maintained clinically significant weight loss? ☐ Yes ☐ No

b. **Age 18 or older:** Has the patient lost at least 5 percent of their baseline body weight? ☐ Yes ☐ No*

***If NO,** has the patient continued to maintain their initial 5 percent weight loss? ☐ Yes ☐ No