Reference number(s)
6947-C

Initial Prior Authorization with Quantity Limit Zepbound FE Compatible Weight Loss Management

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths except the vials, which are covered under the LillyDirect manufacturer program. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Mounjaro	tirzepatide
Zepbound	tirzepatide

Indications

FDA-approved Indications

Tirzepatide (Brand Zepbound and Brand Mounjaro)

Zepbound is indicated in combination with a reduced-calorie diet and increased physical activity:

- to reduce excess body weight and maintain weight reduction long term in adults with obesity or adults with overweight in the presence of at least one weight-related comorbid condition.
- to treat moderate to severe obstructive sleep apnea (OSA) in adults with obesity.

Limitations of Use

- Zepbound contains tirzepatide. Coadministration with other tirzepatide-containing products or with any glucagon-like peptide-1 (GLP-1) receptor agonist is not recommended.

Mounjaro is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

Limitations of Use

- Mounjaro has not been studied in patients with a history of pancreatitis.
- Mounjaro is not indicated for use in patients with type 1 diabetes mellitus.

Coverage Criteria

Approval for all indications will be for tirzepatide.

Obstructive Sleep Apnea

Authorization may be granted when the requested drug will be used with a reduced-calorie diet AND increased physical activity to treat moderate to severe obstructive sleep apnea (OSA) in an adult with obesity when ALL of the following criteria are met:

- The patient has an established diagnosis of moderate to severe OSA with an apnea-hypopnea index (AHI) of at least 15 events per hour on polysomnography (PSG) or home sleep apnea test (HSAT) with a technically adequate device. [ACTION REQUIRED: Documentation is required for approval.]
- The patient has a current body mass index (BMI) greater than or equal to 30 kg/m^2. [ACTION REQUIRED: Documentation is required for approval.]

Reduction in Excess Body Weight, Maintenance of Weight Reduction Long Term

Authorization may be granted when the requested drug will be used with a reduced-calorie diet AND increased physical activity to reduce excess body weight or maintain weight reduction long term in an adult when ALL of the following criteria are met:

- The patient has participated in a comprehensive weight management program that encourages behavioral modification, reduced-calorie diet, AND increased physical activity with continuing follow-up for at least 6 months prior to using drug therapy.
- The patient meets ONE of the following:
    - The patient has a baseline body mass index (BMI) greater than or equal to 30 kg/m^2. [ACTION REQUIRED: Documentation is required for approval.] [NOTE: If the patient is transitioning from another drug therapy for weight loss, please consider their baseline BMI at the start of any drug therapy.]
    - The patient has a baseline BMI greater than or equal to 27 kg/m^2. [ACTION REQUIRED: Documentation is required for approval.] [NOTE: If the patient is transitioning from another drug therapy for weight loss, please consider their baseline BMI at the start of any drug therapy.] In addition, the following criteria is met:
        - The patient has at least ONE weight-related comorbid condition (e.g., hypertension, type 2 diabetes mellitus, dyslipidemia). [ACTION REQUIRED:

Documentation is required for approval.] [NOTE: If the patient is transitioning from another drug therapy for weight loss, please consider their weight-related comorbid condition(s) at the start of any drug therapy.]

Continuation of Therapy

Approval for all indications will be for tirzepatide.

Obstructive Sleep Apnea

Authorization may be granted when the requested drug will be used with a reduced-calorie diet AND increased physical activity to treat moderate to severe obstructive sleep apnea (OSA) in an adult with obesity when ALL of the following criteria are met:

- The patient has an established diagnosis of moderate to severe OSA with an apnea-hypopnea index (AHI) of at least 15 events per hour on polysomnography (PSG) or home sleep apnea test (HSAT) with a technically adequate device. [ACTION REQUIRED: Documentation is required for approval.]
- The patient has achieved or maintained a positive response to treatment from baseline, evidenced by a decrease in OSA symptoms.
- The patient is being treated with a maintenance dosage of the requested drug which is based on individual treatment response and tolerability.

Reduction in Excess Body Weight, Maintenance of Weight Reduction Long Term

Authorization may be granted when the requested drug will be used with a reduced-calorie diet AND increased physical activity to reduce excess body weight or maintain weight reduction long term in an adult when ALL of the following criteria are met:

- The patient has completed at least 3 months of therapy with the requested drug at a stable maintenance dose.
- The patient has lost at least 5 percent of baseline body weight OR the patient has continued to maintain their initial 5 percent weight loss. [ACTION REQUIRED: Documentation is required for approval.]

Quantity Limits Apply

The duration of 21 days is used for a 28-day fill period and 63 days is used for an 84-day fill period to allow time for refill processing.

Drug	Dosage	1 Month Limit	3 Month Limit
Tirzepatide (Brand Mounjaro)	2.5 mg / 0.5 mL	2 mL (1 package of 4 pens each / 21 days	6 mL (3 packages of 4 pens each) / 63 days
Tirzepatide (Brand Mounjaro)	5 mg / 0.5 mL	2 mL (1 package of 4 pens each) / 21 days	6 mL (3 packages of 4 pens each) / 63 days
Tirzepatide (Brand Mounjaro)	7.5 mg / 0.5 mL	2 mL (1 package of 4 pens each) / 21 days	6 mL (3 packages of 4 pens each) / 63 days
Tirzepatide (Brand Mounjaro)	10 mg / 0.5 mL	2 mL (1 package of 4 pens each) / 21 days	6 mL (3 packages of 4 pens each) / 63 days
Tirzepatide (Brand Mounjaro)	12.5 mg / 0.5 mL	2 mL (1 package of 4 pens each) / 21 days	6 mL (3 packages of 4 pens each) / 63 days
Tirzepatide (Brand Mounjaro)	15 mg / 0.5 mL	2 mL (1 package of 4 pens each) / 21 days	6 mL (3 packages of 4 pens each) / 63 days

Duration of Approval (DOA)

- 6947-C:
  - Obstructive Sleep Apnea (OSA): Initial therapy DOA: 6 months; Continuation of therapy DOA: 12 months
  - Reduction in excess body weight, maintenance of weight reduction long term: Initial therapy DOA: 8 months; Continuation of therapy DOA: 12 months

References

1. Zepbound [package insert]. Indianapolis, IN: Lilly USA, LLC; December 2024.
2. Mounjaro [package insert]. Indianapolis, IN: Lilly USA, LLC; November 2024.
3. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2025. https://online.lexi.com. Accessed April 15, 2025.
4. Micromedex® (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: https://www.micromedexsolutions.com/ (cited: 04/15/2025).
5. Jensen MD, Ryan DH, Apovian DM, et al. 2013 AHA/ACC/TOS Guideline for the Management of Overweight and Obesity in Adults A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the Obesity Society. Circulation. 2014;129(suppl 2):S102-S138.
6. Apovian CM, Aronne LJ, Bessesen DH, et al. Pharmacological Management of Obesity: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab. 2015;100(2):342–362.
7. Malhorta A, Grunstein RR, Fietze I, et al. Tirzepatide for the Treatment of Obstructive Sleep Apnea and Obesity. New Engl J Med. 2024;391:1193-1205.

8. Kapur VK, Auckley DH, Chowdhuri S, et al. Clinical Practice Guideline for Diagnostic Testing for Adult Obstructive Sleep Apnea: An American Academy of Sleep Medicine Clinical Practice Guideline. J Clin Sleep Med. 2017;13(3):479-504.

Document History

Written by: UM Development (MRS)

Date Written: 04/2025

Revised: KEJ 07/2025 (updated disclaimer)

Reviewed: Medical Affairs: 05/2025, 07/24/2025

External Review: 08/2025 (FYI)

Guidelines for Approval

Sets 1 – 7

Quantity for Approval 1 package of 4 pens per 21 days, 3 packages of 4 pens per 63 days

Set 1 – Weight Continuation

Duration of Approval 12 Months

Yes to question(s)	No to question(s)
1, 2, 3, 4	5

Set 2 – Weight Initial, BMI 27-30 + risk factor

Duration of Approval 8 Months

Yes to question(s)	No to question(s)
1, 6, 8, 9, 10, 11	2, 7, 18

Set 3 – Weight Initial, BMI 30-35

Duration of Approval 8 Months

Yes to question(s)	No to question(s)
1, 6, 12, 13	2, 7, 8, 18

Set 4 – Weight Initial, BMI 35-40

Duration of Approval 8 Months

Yes to question(s)	No to question(s)
1, 6, 14, 15	2, 7, 8, 12, 18

Set 5 – Weight Initial, BMI > 40

Duration of Approval 8 Months

Yes to question(s)	No to question(s)
1, 6, 16, 17	2, 7, 8, 12, 14, 18

Set 6 – OSA Continuation

Duration of Approval 12 Months

Yes to question(s)	No to question(s)
19, 20, 21, 22, 23, 24	1, 25

Set 7 – OSA Initial

Duration of Approval 6 Months

Yes to question(s)	No to question(s)
19, 20, 21, 26, 27	1, 22, 28

CRITERIA FOR APPROVAL

1	Will the requested drug be used with a reduced-calorie diet AND increased physical activity to reduce excess body weight or maintain weight reduction long term in an adult? [If Yes, then go to 2. If No, then go to 19.]	Yes	No
2	Has the patient completed at least 3 months of therapy with the requested drug at a stable maintenance dose? [If the patient is transitioning from another drug therapy for weight loss, please answer no and proceed.] [If Yes, then go to 3. If No, then go to 6.]	Yes	No
3	Has the patient lost at least 5 percent of baseline body weight OR has the patient continued to maintain their initial 5 percent weight loss? ACTION REQUIRED: If yes, then documentation is required for approval. Document the patient's weight prior to starting drug therapy for weight loss and the patient's current weight, including the dates the weights were taken: _____ [If Yes, then go to 4. If No, then no further questions.]	Yes	No

4	Has documentation of the patient's weight prior to starting drug therapy for weight loss and the patient's current weight, including the dates the weights were taken been submitted to CVS Health? [If Yes, then go to 5. If No, then no further questions.]	Yes	No
5	Does the patient require MORE than the plan allowance of 1 package/4 pens of any of the following per month: A) tirzepatide (Brand Mounjaro) 2.5 mg/0.5 mL, B) tirzepatide (Brand Mounjaro) 5 mg/0.5 mL, C) tirzepatide (Brand Mounjaro) 7.5 mg/0.5 mL, D) tirzepatide (Brand Mounjaro) 10 mg/0.5 mL, E) tirzepatide (Brand Mounjaro) 12.5 mg/0.5 mL, F) tirzepatide (Brand Mounjaro) 15 mg/0.5 mL? [No further questions] RPh Note: If yes, then deny and enter a partial approval per Quantity Limit Chart.	Yes	No
6	Has the patient participated in a comprehensive weight management program that encourages behavioral modification, reduced-calorie diet, AND increased physical activity with continuing follow-up for at least 6 months prior to using drug therapy? [If Yes, then go to 7. If No, then no further questions.]	Yes	No
7	Does the patient have a baseline body mass index (BMI) of less than 27 kg/m2? [If the patient is transitioning from another drug therapy for weight loss, please consider their baseline BMI at the start of any drug therapy when answering this question.] [If Yes, then no further questions. If No, then go to 8.]	Yes	No
8	Does the patient have a baseline body mass index (BMI) of 27 kg/m2 to less than 30 kg/m2? [If the patient is transitioning from another drug therapy for weight loss, please consider their baseline BMI at the start of any drug therapy when answering this question.] ACTION REQUIRED: If yes, then prescriber MUST submit chart notes that show the patient's baseline BMI. _____ [If Yes, then go to 9. If No, then go to 12.] Tech Note: Leave response as answered by prescriber. Verification of chart notes will be addressed in the next question.	Yes	No
9	Have chart notes showing the patient's baseline body mass index (BMI) been submitted to CVS Health? [If the patient is transitioning from another drug therapy for weight loss, please provide their baseline BMI at the start of any drug therapy.] *ACTION REQUIRED: Submit supporting documentation*	Yes	No

	[If Yes, then go to 10. If No, then no further questions.] Tech Note: If the PA is worked over the phone, then the prescriber still MUST submit physical chart notes.		
10	Does the patient have at least ONE weight-related comorbid condition (e.g., hypertension, type 2 diabetes mellitus, dyslipidemia)? [If the patient is transitioning from another drug therapy for weight loss, please consider their weight-related comorbid condition(s) at the start of any drug therapy when answering this question.] ACTION REQUIRED: If yes, then prescriber MUST submit chart notes that indicate the patient's weight-related comorbid condition(s). _____ [If Yes, then go to 11. If No, then no further questions.] Tech Note: Leave response as answered by prescriber. Verification of chart notes will be addressed in the next question.	Yes	No
11	Have chart notes indicating the patient's weight-related comorbid condition(s) been submitted to CVS Health? [If the patient is transitioning from another drug therapy for weight loss, please provide their weight-related comorbid condition(s) at the start of any drug therapy.] *ACTION REQUIRED: Submit supporting documentation* [If Yes, then go to 18. If No, then no further questions.] Tech Note: If the PA is worked over the phone, then the prescriber still MUST submit physical chart notes.	Yes	No
12	Does the patient have a baseline body mass index (BMI) of 30 kg/m2 to less than 35 kg/m2? [If the patient is transitioning from another drug therapy for weight loss, please consider their baseline BMI at the start of any drug therapy when answering this question.] ACTION REQUIRED: If yes, then prescriber MUST submit chart notes that show the patient's baseline BMI. _____ [If Yes, then go to 13. If No, then go to 14.] Tech Note: Leave response as answered by prescriber. Verification of chart notes will be addressed in the next question.	Yes	No
13	Have chart notes showing the patient's baseline body mass index (BMI) been submitted to CVS Health? [If the patient is transitioning from another drug therapy for weight loss, please provide their baseline BMI at the start of any drug therapy.] *ACTION REQUIRED: Submit supporting documentation*	Yes	No

	[If Yes, then go to 18. If No, then no further questions.] Tech Note: If the PA is worked over the phone, then the prescriber still MUST submit physical chart notes.		
14	Does the patient have a baseline body mass index (BMI) of 35 kg/m2 to less than 40 kg/m2? [If the patient is transitioning from another drug therapy for weight loss, please consider their baseline BMI at the start of any drug therapy when answering this question.] ACTION REQUIRED: If yes, then prescriber MUST submit chart notes that show the patient's baseline BMI. _____ [If Yes, then go to 15. If No, then go to 16.] Tech Note: Leave response as answered by prescriber. Verification of chart notes will be addressed in the next question.	Yes	No
15	Have chart notes showing the patient's baseline body mass index (BMI) been submitted to CVS Health? [If the patient is transitioning from another drug therapy for weight loss, please provide their baseline BMI at the start of any drug therapy.] *ACTION REQUIRED: Submit supporting documentation* [If Yes, then go to 18. If No, then no further questions.] Tech Note: If the PA is worked over the phone, then the prescriber still MUST submit physical chart notes.	Yes	No
16	Does the patient have a baseline body mass index (BMI) of 40 kg/m2 or greater? [If the patient is transitioning from another drug therapy for weight loss, please consider their baseline BMI at the start of any drug therapy when answering this question.] ACTION REQUIRED: If yes, then prescriber MUST submit chart notes that show the patient's baseline BMI. _____ [If Yes, then go to 17. If No, then no further questions.] Tech Note: Leave response as answered by prescriber. Verification of chart notes will be addressed in the next question.	Yes	No
17	Have chart notes showing the patient's baseline body mass index (BMI) been submitted to CVS Health? [If the patient is transitioning from another drug therapy for weight loss, please provide their baseline BMI at the start of any drug therapy.] *ACTION REQUIRED: Submit supporting documentation* [If Yes, then go to 18. If No, then no further questions.]	Yes	No

	Tech Note: If the PA is worked over the phone, then the prescriber still UST submit physical chart notes.		
18	Does the patient require MORE than the plan allowance of 1 package/4 pens of any of the following per month: A) tirzepatide (Brand Mounjaro) 2.5 mg/0.5 mL, B) tirzepatide (Brand Mounjaro) 5 mg/0.5 mL, C) tirzepatide (Brand Mounjaro) 7.5 mg/0.5 mL, D) tirzepatide (Brand Mounjaro) 10 mg/0.5 mL, E) tirzepatide (Brand Mounjaro) 12.5 mg/0.5 mL, F) tirzepatide (Brand Mounjaro) 15 mg/0.5 mL? [No further questions] RPh Note: If yes, then deny and enter a partial approval per Quantity Limit Chart.	Yes	No
19	Will the requested drug be used with a reduced-calorie diet and increased physical activity to treat moderate to severe obstructive sleep apnea (OSA) in an adult with obesity? [If Yes, then go to 20. If No, then no further questions.]	Yes	No
20	Does the patient have an established diagnosis of moderate to severe obstructive sleep apnea (OSA) with an apnea-hypopnea index (AHI) of at least 15 events per hour on polysomnography (PSG) or home sleep apnea test (HSAT) with a technically adequate device? ACTION REQUIRED: If yes, then prescriber MUST submit chart notes showing the patient's AHI on PSG or HSAT. _____ [If Yes, then go to 21. If No, then no further questions.] Tech Note: Leave response as answered by prescriber. Verification of chart notes will be addressed in the next question.	Yes	No
21	Have chart notes showing the patient's apnea-hypopnea index (AHI) of at least 15 events per hour on polysomnography (PSG) or home sleep apnea test (HSAT) been submitted to CVS Health? *ACTION REQUIRED: Submit supporting documentation* [If Yes, then go to 22. If No, then no further questions.] Tech Note: If the PA is worked over the phone, then the prescriber still MUST submit physical chart notes.	Yes	No
22	Is this request for continuation of therapy? [If Yes, then go to 23. If No, then go to 26.]	Yes	No

23	Has the patient achieved or maintained a positive response to treatment from baseline, evidenced by a decrease in obstructive sleep apnea (OSA) symptoms? [If Yes, then go to 24. If No, then no further questions.]	Yes	No
24	Is the patient being treated with a maintenance dosage of the requested drug which is based on individual treatment response and tolerability? [If Yes, then go to 25. If No, then no further questions.]	Yes	No
25	Does the patient require MORE than the plan allowance of 1 package/4 pens of any of the following per month: A) tirzepatide (Brand Mounjaro) 2.5 mg/0.5 mL, B) tirzepatide (Brand Mounjaro) 5 mg/0.5 mL, C) tirzepatide (Brand Mounjaro) 7.5 mg/0.5 mL, D) tirzepatide (Brand Mounjaro) 10 mg/0.5 mL, E) tirzepatide (Brand Mounjaro) 12.5 mg/0.5 mL, F) tirzepatide (Brand Mounjaro) 15 mg/0.5 mL? [No further questions] RPh Note: If yes, then deny and enter a partial approval per Quantity Limit Chart.	Yes	No
26	Does the patient have a current body mass index (BMI) of 30 kg/m2 or greater? [ACTION REQUIRED: If yes, then prescriber MUST submit chart notes that show the patient's current BMI. _____ [If Yes, then go to 27. If No, then no further questions.] Tech Note: Leave response as answered by prescriber. Verification of chart notes will be addressed in the next question.	Yes	No
27	Have chart notes showing the patient's current body mass index (BMI) been submitted to CVS Health? *ACTION REQUIRED: Submit supporting documentation* [If Yes, then go to 28. If No, then no further questions.] Tech Note: If the PA is worked over the phone, then the prescriber still MUST submit physical chart notes.	Yes	No
28	Does the patient require MORE than the plan allowance of 1 package/4 pens of any of the following per month: A) tirzepatide (Brand Mounjaro) 2.5 mg/0.5 mL, B) tirzepatide (Brand Mounjaro) 5 mg/0.5 mL, C) tirzepatide (Brand Mounjaro) 7.5 mg/0.5 mL, D) tirzepatide (Brand Mounjaro) 10 mg/0.5 mL, E) tirzepatide (Brand Mounjaro) 12.5 mg/0.5 mL, F) tirzepatide (Brand Mounjaro) 15 mg/0.5 mL? [No further questions]	Yes	No

RPh Note: If yes, then deny and enter a partial approval per Quantity Limit Chart.

Mapping Instructions			
	Yes	**No**	**DENIAL REASONS**
1.	Go to 2	Go to 19	
2.	Go to 3	Go to 6	
3.	Go to 4	Deny	Your plan only covers this drug when you experience benefits from taking the drug. We have denied your request because you did not have good outcomes from the drug. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Continuation, Efficacy, Positive Response]
4.	Go to 5	Deny	Your plan only covers this drug when you experience benefits from taking the drug and when your results from taking the drug are sent to us. Your doctor needs to send us all of the following: A) Your weight prior to starting weight loss drug therapy, B) Your weight now, and C) The dates your weights were taken. We have denied your request because we did not receive all of your results. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Lab/test for weight with documentation]
5.	Deny	[PA approved for 12 months. See Quantity	We have denied your request because it is for more than the amount your plan covers (quantity limit). We reviewed the information we had. We have partially approved your request for this drug up to the amount your plan covers (1 package of 4 pens per month). Your request for more drug has been denied. Your

		Limit Chart.]. Approve, 12 Months	doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Quantity, Exceeds max limit, Partial denial]
6.	Go to 7	Deny	Your plan only covers this drug if you have been in a comprehensive weight management program for at least 6 months before starting this drug. We have denied your request because you have not been taking part in a comprehensive weight management program for at least 6 months. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: No comprehensive weight management program]
7.	Deny	Go to 8	Your plan only covers this drug when it is used for certain health conditions. Covered uses are when you have: A) An initial body mass index (BMI) of at least 30 kg/m2, or B) An initial BMI of 27 kg/m2 to less than 30 kg/m2 with one or more weight-related health conditions. Your plan does not cover this drug for your health condition that your doctor told us you have. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Diagnosis, Weight Loss]
8.	Go to 9	Go to 12	
9.	Go to 10	Deny	Your plan only covers this drug when records with your initial body mass index (BMI) are sent to us. Your records must be provided

			and must show what your doctor tells us. We denied your request because we did not receive your records. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Weight Loss, BMI Documentation]
10.	Go to 11	Deny	Your plan only covers this drug when it is used for certain health conditions. Covered uses are when you have: A) An initial body mass index (BMI) of at least 30 kg/m2, or B) An initial BMI of 27 kg/m2 to less than 30 kg/m2 with one or more weight-related health conditions. Your plan does not cover this drug for your health condition that your doctor told us you have. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Diagnosis, Weight Loss]
11.	Go to 18	Deny	Your plan only covers this drug when records with your weight-related health condition(s) are sent to us. Your records must be provided and must show what your doctor tells us. We denied your request because we did not receive your records. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Comorbidity Documentation]
12.	Go to 13	Go to 14	
13.	Go to 18	Deny	Your plan only covers this drug when records with your initial body mass index (BMI) are sent to us. Your records must be provided and must show what your doctor tells us. We denied your request

			because we did not receive your records. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Weight Loss, BMI Documentation]
14.	Go to 15	Go to 16	
15.	Go to 18	Deny	Your plan only covers this drug when records with your initial body mass index (BMI) are sent to us. Your records must be provided and must show what your doctor tells us. We denied your request because we did not receive your records. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Weight Loss, BMI Documentation]
16.	Go to 17	Deny	Your plan only covers this drug when it is used for certain health conditions. Covered uses are when you have: A) An initial body mass index (BMI) of at least 30 kg/m2, or B) An initial BMI of 27 kg/m2 to less than 30 kg/m2 with one or more weight-related health conditions. Your plan does not cover this drug for your health condition that your doctor told us you have. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Diagnosis, Weight Loss]
17.	Go to 18	Deny	Your plan only covers this drug when records with your initial body mass index (BMI) are sent to us. Your records must be provided and must show what your doctor tells us. We denied your request because we did not receive your records. Your request has been

			denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Weight Loss, BMI Documentation]
18.	Deny	[PA approved for 8 months. See Quantity Limit Chart.]. Approve, 8 Months	We have denied your request because it is for more than the amount your plan covers (quantity limit). We reviewed the information we had. We have partially approved your request for this drug up to the amount your plan covers (1 package of 4 pens per month). Your request for more drug has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Quantity, Exceeds max limit, Partial denial]
19.	Go to 20	Deny	Your plan only covers this drug when it is used for certain health conditions as part of a healthy living plan supported by the FDA (United States Food and Drug Administration). Covered uses are to A) Decrease body weight in obese or overweight adults, B) Maintain weight loss long term in obese or overweight adults, and C) Treat moderate to severe obstructive sleep apnea (OSA) in obese adults. When using this drug for these health conditions, you must be on a low calorie diet and do physical activity. Your plan does not cover this drug for your health condition that your doctor told us you have, or you will not be on a low calorie diet and doing physical activity while taking this drug. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Diagnosis, per indication]

20.	Go to 21	Deny	Your plan only covers this drug if you have moderate to severe obstructive sleep apnea (OSA) as shown by a sleep study. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: OSA, Disease severity]
21.	Go to 22	Deny	Your plan only covers this drug when records showing you have moderate to severe obstructive sleep apnea (OSA) are sent to us. Your records must be provided and must show what your doctor tells us. We denied your request because we did not receive your records or the records did not show what your doctor has told us. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: OSA, Disease Documentation]
22.	Go to 23	Go to 26	
23.	Go to 24	Deny	Your plan only covers this drug when you experience benefits from taking the drug. We have denied your request because you did not have good outcomes from the drug. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Continuation, Efficacy, Positive Response]
24.	Go to 25	Deny	Your plan only continues to cover this drug when you are taking a maintenance dose of this drug. We reviewed the information we had. Your request has been denied. Your doctor can send us any

			new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: OSA, Maintenance Dosing]
25.	Deny	[PA approved for 12 months. See Quantity Limit Chart.]. Approve, 12 Months	We have denied your request because it is for more than the amount your plan covers (quantity limit). We reviewed the information we had. We have partially approved your request for this drug up to the amount your plan covers (1 package of 4 pens per month). Your request for more drug has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Quantity, Exceeds max limit, Partial denial]
26.	Go to 27	Deny	Your plan only covers this drug for obstructive sleep apnea (OSA) if your current body mass index (BMI) is 30 kg/m2 or higher. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: OSA, Exclusion for BMI]
27.	Go to 28	Deny	Your plan only covers this drug when records with your current body mass index (BMI) are sent to us. Your records must be provided and must show what your doctor tells us. We denied your request because we did not receive your records. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: OSA, BMI Documentation]

28.	Deny	[PA approved for 6 months. See Quantity Limit Chart.]. Approve, 6 Months	We have denied your request because it is for more than the amount your plan covers (quantity limit). We reviewed the information we had. We have partially approved your request for this drug up to the amount your plan covers (1 package of 4 pens per month). Your request for more drug has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Quantity, Exceeds max limit, Partial denial]