STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
PO BOX 2943 HARTFORD, CT 06104
TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110

CT Medical Assistance Program *Zepbound* for Treatment of Obstructive Sleep Apnea Prior Authorization (PA) Request Form

[This and other pharmacy PA forms are available at www.ctdssmap.com]

To Be Completed By Prescriber

Prescriber Information	Patient Information
Prescriber's NPI:	Member's Name (Last, First):
Prescriber's Name:	Member's ID:
Phone:	Member's Date of Birth (MMDDCCYY):
Fax:	Requested Zepbound Strength:

Criteria for Medical Necessity Review

Section 1 Initial Zepbound Request for Obstructive Sleep Apnea Only		
1.) Patient is 18 years of age or older?	□ Yes	□ No
2.) Is the patient diagnosed with type 1 or type 2 diabetes, mixed sleep apnea or central sleep apnea?	□ Yes**	□ No
3.) Does patient have a diagnosis of obstructive sleep apnea (OSA) with an apnea-hypopnea index (AHI) greater than or equal to 15?	□ Yes	□ No
4.) Is patient currently using AND will continue to use positive airway pressure treatment (PAP) unless a contraindication to PAP exists?	□ Yes	□ No
5.) Is the patient's body mass index (BMI) greater than or equal to 30?	□ Yes	□ No
6.) Does the patient's treatment plan include active participation in comprehensive adjunct lifestyle interventions (e.g. diet modifications, physical activity, nutritional counseling and/or behavioral therapy)?	□ Yes	□ No

**** If *Question 2* in Section 1 (initial request) is answered as "Yes," or if questions 1,3,4,5, and 6 are answered as "No," the product is not covered. A Letter of Medical Necessity (LMN) must be reviewed for consideration. Please provide all relevant information relating to medical necessity (see Conn. Gen. Stat 17b-259b (a)) for this patient. Submit request via email, to rx.lmn@ct.gov**

Section 2 Subsequent Requests for Zepbound Continuation for Obstructive Sleep Apnea Only		
1.) Has the patient previously met the required criteria set forth in Section 1 above (Initial Medication Request)? a.) Previous Approved Prior Authorization Number: _____ Date: _____	□ Yes	□ No
2.) Does patient continue to participate in comprehensive adjunct lifestyle intervention plan (e.g. diet and exercise program, nutritional counseling and/or calorie restricted diet)?	□ Yes	□ No
3.) Has there been a positive clinical response demonstrated by at least a 25% reduction from baseline in AHI?	□ Yes	□ No
4.) Does patient continue to use PAP therapy unless contraindicated?	□ Yes	□ No

If you answered "No" to any question in Section 2 (continuation request), a Letter of Medical Necessity (LMN) must be reviewed for consideration. Please provide all relevant information relating to the medical necessity (see Conn. Gen. Stat. § 17b-259b(a)) of this drug for this patient. Submit request, via email, to rx.lmn@ct.gov.

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.

I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under Connecticut Gen. Stat. Section 17b-99 and Regs. Conn. State Agencies Sections 17-83k-1-3 and 4a –7, inclusive. I certify that the client is under my clinic's/practice's ongoing care. I understand that Prior Authorizations will not exceed 6 months from date of fill for controlled medications and 1 year for non-controlled medications/products, except for Early Refill Requests, which are valid one time only.

Prescriber Signature: _____ Date: _____

* Mandatory (others may not sign for prescriber). In accordance to mandates set forth in the Affordable Care Act (ACA), providers who order, prescribe, or refer clients for services must be enrolled in the Connecticut Medical Assistance Program (CMAP). Effective 10/1/2013, any prescriptions or services provided by a non-enrolled provider will no longer be considered/covered by CMAP.