Mounjaro (tirzepatide)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

Revision Date: 11/01/2022

Magellan Rx MANAGEMENT

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Type II diabetes ☐ Other diagnosis: _____ICD-10:_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Is the drug going to be used in conjunction with a clinical trial? ☐ Yes ☐ No

Does patient have a HbA1c greater than or equal to 7% in the last 6 months or prior to starting therapy? ☐ Yes ☐ No *Please submit documentation.*

Is the patient currently on metformin? ☐ Yes ☐ No *Please submit documentation.*

Has the patient failed treatment with, or had an intolerance to, metformin? ☐ Yes ☐ No *Please submit documentation.*

Does the patient have an estimated GFR is less than 30 ml/min/1.73m^2? ☐ Yes ☐ No *Please submit documentation.*

Does the patient have advanced liver disease with cirrhosis, portal hypertension, ascites, and/or hepatic encephalopathy? ☐ Yes ☐ No *Please submit documentation.*

Has the patient tried a GLP-1 or a combination of GLP-1's such as Ozempic (semaglutide), Victoza (liraglutide), Rybelsus (semaglutide), Byetta (exenatide), Bydureon (exenatide), Bydureon BCise, OR Trulicity (dulaglutide) for a total GLP-1 use of at least 6 months? ☐ Yes ☐ No *Please submit documentation.*

Does the patient have a BMI greater than or equal to 23 kg/m^2 ? ☐ Yes ☐ No *Please submit documentation.*

Does the patient have a personal or family history of medullary thyroid carcinoma or personal history of multiple endocrine neoplasia syndrome Type 2? ☐ Yes ☐ No

Is the patient going to take Mounjaro (tirzepatide) in combination with a GLP-1 such as Ozempic (semaglutide), Victoza (liraglutide), Rybelsus (semaglutide), Byetta (exenatide), Bydureon (exenatide), Bydureon BCise or Trulicity (dulaglutide)? ☐ Yes ☐ No

Will the patient use Mounjaro (tirzepatide) in combination with a DPP-4 such as Januvia, Janumet, Janumet XR, Tradjenta, Jentadueto (XR), Onglyza, Kombiglyze XR, Nesina, Kazano, Oseni, Glyxambi, Seglujan, Qtern? ☐ Yes ☐ No

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

_____

_____

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***Please note:** Not all drugs/diagnoses are covered on all plans. This request may be denied unless all required information is received.
ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form. **Prescriber Signature or Electronic I.D. Verification:** _____ **Date:** _____
CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811