Mounjaro (tirzepatide)
Prior Authorization Request Form

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

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

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: PRIMETHERAPEUTICS.COM/NOPP

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:**
REQUESTER (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):			

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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 ☐ Type II Diabetes with established cardiovascular disease ☐ Other diagnosis: _____ ICD-10 Code(s):	

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

Is patient going to be using drug in combination with a clinical trial? ☐ **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**

Has the patient tried generic liraglutide for at least 6 months AND not come to HbA1c level of less than 8%?□ **Yes** □ **No** ***Please submit documentation.***

Does patient have an absolute contraindication to generic liraglutide? □ **Yes** □ **No** ***Please submit documentation.***

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), Byetta (exenatide), Bydureon (exenatide), Bydureon BCise, OR Trulicity (dulaglutide) for a total GLP-1 use of at least 6 months AND not come to HbA1c level of less than 8%? □ **Yes** □ **No** ***Please submit documentation.***

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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), or Trulicity (dulaglutide)? □ Yes □ No

Does the patient have Type II diabetes with established cardiovascular disease? □ Yes □ No *Please submit documentation*

Does patient have a hemoglobin A1c (HbA1c) of ≥ 7% and ≤ 10.5%? □ Yes □ No *Please submit documentation.*

Does patient have a BMI of ≥25kg/m^2? □ Yes □ No *Please submit documentation.*

Does patient have established cardiovascular disease with any of the following? *Please submit documentation.*

- **Coronary artery disease(CAD) with any of the following:**
  - **□Documented history of spontaneous myocardial infarction(MI)(documentation required),OR**
  - **□≥50% stenosis in 1 or more major coronary arteries, (angioplasty results required), OR**
  - **□≥50% stenosis in 2 or more minor coronary arteries, (CTCA results required),OR**
  - **□History of surgical or percutaneous coronary revascularization procedure(documentation required),**
- **Cerebrovascular disease with any of the following:**
  - **□Documented history of ischemic stroke(documentation required), OR**
  - **□Carotid arterial disease with ≥50% stenosis,(documentation required), OR**
  - **□Carotid stenting or surgical revascularization(documentation required),**
- **Peripheral arterial disease with either of the following:**
  - **□Intermittent claudication and ankle-brachial index <0.9 (documentation required), OR**
  - **□Prior nontraumatic amputation or peripheral vascular procedure (eg. Stenting or surgical revascularization), due to peripheral arterial ischemia (documentation required)**

Does patient have Type 1 diabetes? □ Yes □ No *Please submit documentation.*

Does patient have NYHA functional classification IV congestive heart failure? □ Yes □ No *Please submit documentation.*

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

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

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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:** _____

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FAX THIS FORM TO: 800-424-7640
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Attn: CP-4201
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