Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

GLP-1's for Weight Management

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescribing Provider NPI #: _____
3. Requestor Contact Information - Name: _____
4. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name:_____ 2. Strength: _____ 3. Quantity per 30 Days: _____
4. Length of Therapy (in Days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ Other _____

Clinical Information

Initial Request: Wegovy for Cardio protection:

1. Please list the member's baseline weight and BMI. Weight _____ Date _____ BMI _____ Date_____
2. Is the member 45 years of age or older? ☐ **Yes** ☐ **No**
3. Does the member have established cardiovascular disease (CVD) defined as having a history of myocardial infarction, stroke, or symptomatic peripheral arterial disease? ☐ **Yes** ☐ **No** List diagnosis_____
4. Does the member have a personal or family history of medullary thyroid carcinoma? ☐ **Yes** ☐ **No**
5. Does the member have multiple endocrine neoplasia syndrome type 2? ☐ **Yes** ☐ **No**
6. Does the member have at least 3 months of lifestyle modifications prior to starting Wegovy? ☐ **Yes** ☐ **No**
7. Is the member using Wegovy in combo with a reduced calorie diet and increased physical activity unless physical activity is not clinically appropriate at the time GLP1 therapy commences? ☐ **Yes** ☐ **No**

Initial Request Wegovy for NASH/MASH

1. Does the member have a diagnosis of noncirrhotic nonalcoholic steatohepatitis (NASH) or metabolic dysfunction associated steatohepatitis (MASH)? ☐ **Yes** ☐ **No** (medical records required)
2. Does the member have a FIB-4 score consistent with stage F1, F2, or F3 fibrosis adjusted for age? ☐ **Yes** ☐ **No** List Score_____
3. Has the member had one of the following tests? (check)
   - ☐ A liver biopsy
   - ☐ Vibration-controlled transient elastography (VCTE)
   - ☐ Enhanced liver fibrosis (ELF) score
   - ☐ Magnetic resonance elastography (MRE)
4. Is the member 18 years old or over? ☐ **Yes** ☐ **No**
5. What is the member's baseline BMI prior to beginning therapy? **BMI_____ Date_____**
6. Is the member of South Asian, Southeast Asian, or East Asian descent? ☐ **Yes** ☐ **No**
7. Is the member female with alcohol consumption less than 20 grams/day? ☐ **Yes** ☐ **No**
8. Is the member male with alcohol consumption less than 30 grams /day? ☐ **Yes** ☐ **No**
9. Is the member being monitored for development of and/or treated for any comorbid conditions (e.g., cardiovascular disease, diabetes, dyslipidemia, hypertension)? ☐ **Yes** ☐ **No**
10. Does the member have decompensated cirrhosis? ☐ **Yes** ☐ **No**
11. Does the member have moderate to severe hepatic impairment (Child-Pugh Class B or C)? ☐ **Yes** ☐ **No**

12. Does the member have any other liver disease? ☐ **Yes** ☐ **No** List_____
13. Is Wegovy being prescribed by or in consultation with a specialist in the area of the member's diagnosis (e.g., hepatologist, gastroenterologist)? ☐ **Yes** ☐ **No**

Continuation Request: Wegovy for cardioprotection and for NASH/MASH

1. Has the member been previously approved for the requested agent through Medicaid's Prior Authorization process for the covered indications that went into effect 10/01/2025 [Note: beneficiaries not previously approved for the requested agent will require initial evaluation review]? ☐ **Yes** ☐ **No**
2. Has medical documentation that the member has improved while on the medication been included with this request? ☐ **Yes** ☐ **No**
3. Are individual clinical goals set by the provider being met? ☐ **Yes** ☐ **No**
4. Is the member continuing to make adequate progress towards treatment goals? ☐ **Yes** ☐ **No**
5. Is the product prescribed FDA approved for the indication, age, weight (if applicable) and not exceeding dosing limits per the prescribing Information per the clinical conditions for use? ☐ **Yes** ☐ **No**
6. Is the member currently on and will continue lifestyle modification including structured nutrition and physical activity unless physical activity is not clinically appropriate? ☐ **Yes** ☐ **No**
7. Will the member be using the requested agent with another GLP-1? ☐ **Yes** ☐ **No**
8. Does the member have any FDA-labeled contraindications to the requested agent? ☐ **Yes** ☐ **No**
9. Has the provider performed a review of the member's medication list for possible dose reductions or discontinuation of medications for comorbid conditions, which are no longer needed or able to be reduced due to clinical effects of receiving the medication? ☐ **Yes** ☐ **No**

Initial Request: Zepbound for Sleep Apnea

1. Is the member 18 years old or older? ☐ **Yes** ☐ **No**
2. Does the member have moderate to severe obstructive sleep apnea (OSA) with obesity? ☐ **Yes** ☐ **No**
3. Does the member have a documented baseline BMI of > 40kg/ m2 prior to beginning therapy? ☐ **Yes** ☐ **No**
   BMI _____ Date_____
4. Is Zepbound prescribed in accordance with the FDA approved indications, age, weight (if applicable) and not exceed dosing limits per the prescribing Information per the clinical conditions for use? ☐ **Yes** ☐ **No**
5. Is the member currently on and will continue lifestyle modification including structured nutrition and physical activity, unless physical activity is not clinically appropriate at the time GLP1 therapy commences? ☐ **Yes** ☐ **No**
6. Will the member be using the requested agent in combination with another GLP-1 receptor agonist agent? ☐ **Yes** ☐ **No**
7. Does the member does have any FDA-labeled contraindications to the requested agent, including pregnancy, lactation, history of medullary thyroid cancer or multiple endocrine neoplasia type II? ☐ **Yes** ☐ **No**
8. Is documentation attached to this request confirming that sleep apnea testing was performed and sleep apnea was diagnosed? ☐ **Yes** ☐ **No**
9. Has the member been instructed on sleep hygiene modifications before beginning Zepbound (for example, sleep positioning to avoid a non-supine position, avoidance of alcohol and stimulants before bed)? ☐ **Yes** ☐ **No**

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Continuation Request Zepbound for Sleep Apnea:

1. Has the member been previously approved for the requested agent through Medicaid's Prior Authorization process for the covered indications that went into effect 10/01/2025? Note: beneficiaries not previously approved for the requested agent will require initial evaluation review]? ☐ **Yes** ☐ **No**
2. Has medical documentation that member has improved while on the medication been included with this request? ☐ **Yes** ☐ **No**
3. Are Individual clinical goals set by the provider being met? ☐ **Yes** ☐ **No**
4. Is the member continuing to make adequate progress towards treatment goals? ☐ **Yes** ☐ **No**
5. Is Zepbound FDA approved for the indication, age, weight (if applicable) and not exceed dosing limits per the Prescribing Information per the clinical conditions for use? ☐ **Yes** ☐ **No**
6. Is the member currently on and will continue lifestyle modification including structured nutrition and physical activity unless physical activity is not clinically appropriate? ☐ **Yes** ☐ **No**
7. Will the member be using the requested agent with another GLP-1? ☐ **Yes** ☐ **No**
8. Does the member have any FDA-labeled contraindications to the requested agent? ☐ **Yes** ☐ **No**
9. Has the provider performed a review of the member's medication list for possible dose reductions or discontinuation of medications for comorbid conditions, which are no longer needed or able to be reduced due to clinical effects of the medication? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.