State of Idaho, Division of Medicaid
Prior Authorization Form

GIP and GLP-1 Receptor Agonists for Non-Diabetic Patients with Comorbidities

CONFIDENTIAL INFORMATION

Phone: (208) 364-1829 *One drug per form ONLY – Use black or blue ink* **Fax: (800) 327-5541**

Participant Name:		Medicaid ID #:		Date of Birth:	
Prescriber Name:		NPI #:		Specialty:	
Prescriber Phone:		Prescriber Fax:			
Pharmacy NPI #:		Pharmacy Phone:		Pharmacy Fax:	

Idaho Medicaid does not cover agents for weight loss (Social Security Act 1927(2)[324]). Requests must meet FDA approved indications, age limits and doses. Initial approval will be for 3 months with follow up every 3 months documenting weight/BMI reduction (table below). ***For treatment of diabetes, refer to Hypoglycemics-Incretin Mimetics PA form.***

Clinical Criteria:

Chart notes required: *Wegovy® (semaglutide)* may be approved for cardiovascular risk reduction in patient with prior myocardial infarction, prior stroke, or symptomatic peripheral arterial disease with obesity (BMI ≥ 27 kg/m^2).

Chart notes required: *Zepbound® (tirzepatide)* may be approved for confirmed diagnosis of moderate to severe obstructive sleep apnea/hypopnea syndrome in adults with obesity (BMI ≥ 30). Sleep study must be provided with an apnea/hypopnea index (AHI) ≥ 15.

CPAP Compliant: Yes or No (If No, why): _____

Attestation (Required):

- ❑ Patient is compliant with reduced calorie diet.
- ❑ Patient is compliant with increased physical activity for chronic weight management.
- ❑ Patient does not have Type 1 or Type 2 Diabetes Mellitus (A1C <6.5).

Requested agent:

- ❑ *Wegovy® (semaglutide)*
  Dose: _____
- ❑ *Zepbound® (tirzepatide)*
  Frequency: _____

Diagnosis (ICD-10): _____

Weight and BMI (Quarterly follow up required for continued renewal)

	Date	Weight (lbs. or kg)	BMI	% Weight Reduction
Baseline				
3 months				
6 months				
9 months				
12 months				

To ensure continuity of care, please make sure corresponding ICD-10 diagnosis codes are submitted on professional office claims to Medicaid on a routine basis.

Prescriber Signature: _____ MD DO DDS OD PA APRN PharmD **Date:** _____

By signing, the prescriber agrees that documentation of above indication and medical necessity is available for review by Idaho Medicaid in participant's current medical chart.

All current PA forms and criteria for use are available at: http//:www.medicaidpharmacy.idaho.gov (PA Criteria & Forms)

NEW: 1/16/2025