



PRIOR AUTHORIZATION REQUEST

GLP-1 Receptor Agonists for Weight Loss

Prescribing Physician:	
Name (First, Last)	
Direct Phone #	
Fax #	
Physician specialty	

Patient:	
Name (First, Last)	
ID #	Sex (at birth): <input type="checkbox"/> M <input type="checkbox"/> F
Phone #	Client
Birth Date: ____/____/____	Age

Name and title of person completing Form (please print):		Visit type: <input type="checkbox"/> In-person (Face-to-Face) <input type="checkbox"/> Telemedicine	
1. Drug name: <input type="checkbox"/> Wegovy® (semaglutide) Inj <input type="checkbox"/> Wegovy® (semaglutide) tablet <input type="checkbox"/> Saxenda® (liraglutide) Inj <input type="checkbox"/> Zepbound® (tirzepatide) Inj	2. Dose/Strength:	3. Route/Frequency: <input type="checkbox"/> SQ Once Daily <input type="checkbox"/> SQ Once weekly <input type="checkbox"/> PO Once Daily	4. Length of Therapy:
5. Diagnosis/ICD Code:	6. BMI (kg/m2)	7. Baseline weight (lb/kg):	8. Height (inch/cm)

9. Please provide the following values		
	Value	Date
a. LDL		
b. A1c		
c. TSH		
d. Fasting insulin		
e. C-Peptide levels		
	Value	Date
f. Free Testosterone (males)		
g. Vitamin D		
h. Body fat %		
i. Waist circumference		
j. PHQ-9 score		

10. What are the objective weight-loss goals?
11. Please indicate any weight-related comorbidities:
12. Please indicated if the patient has been on a diet and exercise program? If yes, please indicate dates, duration, and outcomes.
13. Please indicate any lifestyle modifications that will be used in addition to medication therapy
14. Has the patient had bariatric surgery in the past? If yes, please indicate date of surgery.
15. If the patient has trialed pharmacologic therapy for weight-loss, please indicate the drug name and dates.

Physician's Name (print): _____ Title: _____

Physician's Signature: _____ Date: ____/____/____