Louisiana Medicaid
Tirzepatide (Zepbound®)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for tirzepatide (Zepbound®). For initiation of therapy requests, the *Tirzepatide (Zepbound®) Treatment Agreement for Louisiana Medicaid Recipients* must be completed as instructed and submitted with the request form.

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

Approval Criteria for Initiation of Therapy

- The recipient is 18 years of age or older on the date of the request; **AND**
- The patient has an established diagnosis of moderate to severe obstructive sleep apnea (OSA) with an apnea-hypopnea index (AHI) of ≥ 15 on polysomnography (PSG) within the previous 12 months **(Documentation is required showing test results with corresponding date)**; **AND**
- The prescriber **states on the request** that the recipient does not have central or mixed sleep apnea; **AND**
- **ONE** of the following is true and **stated on the request**:
    - The requested medication is prescribed concurrently with positive airway pressure (PAP) therapy, unless contraindicated or clinically significant adverse effects are experienced; **OR**
    - The recipient has a history of non-adherence to PAP therapy; **AND**
- The recipient has a documented BMI ≥ 30 kg/m^2 **(Date and results of the most recent BMI calculation are stated on the request)**; **AND**
- The recipient does not have type 1 or type 2 diabetes; **AND**
- The prescriber **states on the request** that the recipient will not use this medication with other tirzepatide products or with any other GLP-1 receptor agonists; **AND**
- The prescriber **states on the request** that tirzepatide treatment will be used as adjunct treatment to standard of care therapy, which includes, but is not limited to:
    - Individualized healthy lifestyle counseling; **AND**
    - Behavioral modification, including a reduced calorie diet and increased physical activity.

Duration of approval for initiation of therapy: 6 months

Approval Criteria for Continuation of Therapy

- **BOTH** of the following is true:
    - The recipient is currently receiving this medication, as evidenced by paid pharmacy claims; **AND**
    - Documentation provided with the request indicates that the recipient met the initial approval criteria and has received this medication for at least 28 days; **AND**
- **ONE** of the following is true and is **stated on the request**:
    - The recipient lost ≥ 5 percent of baseline body weight **OR** has continued to maintain their initial 5 percent weight loss and no additional weight gain (Documentation of the

recipient's baseline weight prior to initiation of therapy and the recipient's current weight, including the date the weights were taken must be submitted); **OR**
    - The recipient **DID NOT** reach the weight loss goal of at least 5 percent and clinical justification for continuation of current therapy is provided; **AND**
- The prescriber **provides supporting documentation of at least 3 months follow up (i.e. clinical visit notes or documentation of updated testing results)** that the recipient has achieved or maintained a positive response to treatment from baseline, evidenced by a decrease in AHI and OSA symptoms; **AND**
- The prescriber **states on the request** that tirzepatide treatment will be used as adjunct treatment to standard of care therapy, which includes, but is not limited to:
    - Individualized healthy lifestyle counseling; **AND**
    - Behavioral modification including a reduced calorie diet and increased physical activity; **AND**
- The request is for a maintenance dose of 10mg or 15mg once weekly (if appropriate based on recipient's current titration schedule).

Duration of approval for continuation / maintenance of therapy: 3-12 months

- **For weight loss ≥ 5%, approve for an additional 12 months.**
- **For weight loss < 5%, approve for 3 months if clinical justification is provided as to why this weight loss goal was not reached (unless previously approved for 3 months – see below).**

If previous duration of approval was for 3 months:

- **For weight loss ≥ 5%, approve for an additional 12 months.**
- **For weight loss < 5%, do not approve.**

References

ClinicalTrials.gov. Obstructive Sleep Apnea Master Protocol GPIF: A Study of Tirzepatide (LY3298176) in Participants With Obstructive Sleep Apnea (SURMOUNT-OSA). https://clinicaltrials.gov/study/NCT05412004

Peppard, P. E., Young, T., Palta, M., Dempsey, J., & Skatrud, J. (2000). Longitudinal study of moderate weight change and sleep-disordered breathing. JAMA, 284(23), 3015–3021.http://jama.jamanetwork.com/article.aspx?doi=10.1001/jama.284.23.3015

Zepbound (tirzepatide) [package insert]. Indianapolis, IN: Lilly USA, LLC; April 2025. https://uspl.lilly.com/zepbound/zepbound.html#pi

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