DisclosedRx
The Fiduciary and Fully Disclosed PBM®

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Prior Authorization Request Form

GIP/GLP-1 & GLP-1 Agonists (Weight Management)

☐Standard ☐Urgent ☐Reconsideration/Appeal

Patient Information

Patient Name: _____ DOB (mm/dd/yyyy): _____ Gender: _____

Address: _____ City: _____ State & Zip: _____

Cardholder ID: _____ Group #: _____ Relationship Code: _____

Phone Number: _____ Email address: _____

Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Address: _____ City: _____ State & Zip: _____

Office Contact: _____ Phone Number: _____ Fax Number: _____

Medication Information

Drug Name: _____ Strength: _____ Quantity: _____

Directions: _____ Day Supply: _____

Indicate Request Type: ☐New Start ☐Renewal Therapy Start Date (if applicable): _____

Diagnosis: _____ ICD 10 Code: _____

Prior Authorization Request Information

Supporting documentation (i.e., chart notes, labs, etc.) must be attached to avoid processing delays

For all requests:

1. Will the requested agent be used in combination with be used concomitantly with another GLP-1 or GLP-1/GIP agonist (i.e. tirzepatide, semaglutide, dulaglutide, liraglutide, etc)? ☐Yes ☐No
2. Does the patient have any FDA contraindications to the requested agent? ☐Yes ☐No
3. Will the patient be taking any other medications in combination with the requested agent for the treatment of this diagnosis? If yes, please list: _____ ☐Yes ☐No

For Weight Loss Management (Wegovy/Zepbound):

4. Please provide the patient's baseline height, weight, and BMI (prior to any GLP-1/GIP agonist):
   Height: _____ Weight: _____ BMI: _____ Date: _____
5. Please provide the patient's current height, weight, and BMI (within the past 3 months):
   Height: _____ Weight: _____ BMI: _____ Date: _____
6. Has the patient participated in at least 6 months in a diet, exercise, and lifestyle modification program/plan immediately prior to this request? Please submit documentation. ☐Yes ☐No
7. Has the patient had an inadequate clinical response of at least 12 weeks, intolerance, or contraindication to ONE of the following sympathomimetic/stimulant medications (phentermine, benzphetamine, diethylpropion/ER, phendimetrazine)? If yes, please list below. ☐Yes ☐No

Please continue to the next page.

Patient Name:	DOB:

Drug Name/Strength:	Start Date:	End Date:	Outcome:

For Cardiovascular Risk Reduction (Wegovy only):

1. **Please provide the patient's current height, weight, and BMI (within the past 3 months):**
   Height: _____ Weight: _____ BMI: _____ Date: _____
2. **Which of the following diagnoses applies to the patient?**
   ☐Prior myocardial infarction ☐Prior stroke ☐Peripheral artery disease ☐Other: _____
3. **Is the patient current being medically managed with the standard of care for the cardiovascular disease that the patient has been diagnosed with?** **☐Yes ☐No**

For Renewal Requests:

1. **Has the patient had a positive clinical response to therapy? Must submit objective documentation.** **☐Yes ☐No**
2. **Does the patient have any FDA contraindications to the requested agent?** **☐Yes ☐No**
3. **For weight management requests: Has the patient achieved and maintained a weight loss of at least 5% from baseline?** **☐Yes ☐No**

Prescriber Signature: _____ **Date: _____**

Authorized Agent's Name: _____

Please fax this request to 602-585-0588 or our secure email at care@disclosedrx.com
Mail Requests to: DisclosedRx Clinical Team
PO Box 701 Washington, IN 47501

Additional Comments/Notes: