PRIOR AUTHORIZATION POLICY

POLICY: Weight Loss – Glucagon-Like Peptide-1 Agonists – Zepbound Prior Authorization Policy
- Zepbound® (tirzepatide subcutaneous injection [KwikPens, pens, and vials] – Eli Lilly)

REVIEW DATE: 06/17/2026

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Zepbound is a glucagon-like peptide-1 (GLP-1)/glucose-dependent insulinotropic polypeptide receptor agonist indicated in combination with a reduced-calorie diet and increased physical activity to[1]:

- **Reduce excess body weight and maintain weight reduction long term** in:
  - Adults with overweight in the presence of at least one weight-related comorbid condition.
  - Adults with obesity.
- Treat **moderate to severe obstructive sleep apnea** (OSA) in adults with obesity.

Concomitant use with another tirzepatide-containing product or GLP-1 receptor agonist is not recommended.[1]

Dosing

In the prescribing information for Zepbound, the recommended starting dose is 2.5 mg subcutaneously once weekly (QW).[1] The 2.5 mg dose is for treatment initiation and is not intended for chronic weight management. The maximum dose is 15 mg QW. The 5 mg, 10 mg, and 15 mg maintenance doses are reached at Week 4, Week 12, and Week 20, respectively.

Clinical Efficacy

OSA

The SURMOUNT-OSA (n = 469) trials were two 52-week, Phase III, multicenter, double-blind, randomized trials that evaluated the efficacy and safety of maximally tolerated Zepbound (10 mg or 15 mg QW) in adults with obesity (without diabetes) and moderate to severe OSA.[2] Two patient populations were included. In Trial 1, patients were unable or unwilling to use positive airway pressure (PAP) therapy, and in Trial 2, patients had been using PAP therapy for ≥ 3 months at the time of screening and planned to continue PAP therapy during the trial. All patients had a diagnosis of moderate to severe OSA with an apnea-hypopnea index (AHI) ≥ 15 events/hour as diagnosed with polysomnography, home sleep apnea test, or other methods that met local guidelines prior to Visit 1. Patients had a body mass index (BMI) of ≥ 30 kg/m^2 (≥ 27 kg/m^2 in Japan) despite the history of at least one self-reported unsuccessful dietary effort to lose weight. Patients with a diagnosis of central or mixed sleep apnea with the percentage of mixed or central apneas/hypopneas ≥ 50%, and Cheyne Stokes respiration were excluded. In Trial 1, the mean BMI was 39.1 kg/m^2 and the mean AHI was 51.5 events/hour. Most patients had severe OSA (63%). In Trial 2, the mean BMI was 38.7 kg/m^2 and the mean AHI was 49.5 events/hour. Most patients had severe OSA (68%). The primary endpoint was the superiority of Zepbound vs. placebo for the change in the AHI from baseline.[9] Several key secondary endpoints were assessed.

Results. In both trials, Zepbound was superior to placebo for the primary endpoint. In Trial 1, the change in AHI at Week 52 with Zepbound was superior to placebo (-25.3 events/hour vs. -5.3 events/hour, respectively; estimated treatment difference of -20.0 events/hour; P < 0.001).[2] In Trial 2, the change in AHI at Week 52 with Zepbound was superior to placebo (-29.3 events/hour vs. -5.5 events/hour, respectively; estimated treatment difference -23.8 events/hour; P < 0.001). Additionally, patients in both trials who received Zepbound had significant reductions in sleep apnea-specific hypoxic burden. The proportion of patients with a reduction in the AHI of ≥ 50% at Week 52 and the proportion of patients with an AHI of < 5 events/hour or an AHI of 5 to 14 events/hour and an ESS of ≤ 10 at Week 52 also favored Zepbound. Patients receiving Zepbound in both trials had significant reductions in body weight.

Guidelines

Weight Management

The American Academy of Clinical Endocrinology (AACE) Consensus Statement: Algorithm for the Evaluation and Treatment of Adults with Obesity/Adiposity-Based Chronic Disease (ABCD) [2025 update] places an emphasis on a complication-centric, person-centered care model.[3] BMI is appropriate to screen for ABCD/obesity and is used to classify individuals into categories of overweight (BMI ≥ 25.0 to ≤ 29.9 kg/m^2), Class I obesity (BMI ≥ 30.0 to ≤ 34.9 kg/m^2), Class II obesity (BMI ≥ 35.0 to ≤ 39.9 kg/m^2), or Class III obesity (BMI ≥ 40 kg/m^2). Pharmacotherapy, in adjunct to lifestyle modification, is indicated to prevent, improve, or reverse obesity-related complications and diseases; not solely to reduce BMI. The choice of pharmacotherapy is based on obesity-related comorbidities. The degree of weight reduction with a given medication can serve as a guide toward improvement of various comorbidities. Response to pharmacologic therapy should be assessed after 3 months on a therapeutic dose. If treatment has not resulted in ≥ 5% weight loss, longer-term efficacy will not likely be sufficient; a change in therapeutic approach is recommended. Individuals with weight reduction ≥ 5% should continue with their current treatment. Patients who achieve ≥ 15% weight loss (noted to be the percent weight loss observed on average with Wegovy injection and Zepbound) will have achieved a response to therapy that predictably prevents or improves a wide range of obesity-related comorbidities.

The American Diabetes Association Professional Practice Committee for Obesity (2026) Standards of Care in Overweight and Obesity prioritize obesity pharmacotherapy that is most likely to achieve and maintain intended treatment goals.[4] The treatment goal should be individualized based on the severity of obesity, obesity-related complications and diseases, and individual needs. A sustained weight reduction of ≥ 5% from baseline may achieve some clinically meaningful health benefits, while a sustained weight reduction of ≥ 10% is recommended to manage many obesity-related diseases or complications. In some cases, ≥ 15% weight reduction may be indicated to achieve greater therapeutic benefit. Zepbound and Wegovy injection (listed in order of relative benefit) are recognized as agents with high efficacy (> 10% weight loss). Medications should be continued after reaching treatment goals to maintain health benefits. When there is an inadequate response to therapy, dose escalation to the maximum dose is recommended. If the maximum dose has been reached and the response is inadequate, switching to an alternative medication, adding intensive lifestyle therapy, combining medications, or referring for metabolic surgery is recommended. Patients who achieve early weight reduction (usually ≥ 5% after 3 months) should continue medication long term.

Sleep Apnea

The American Academy of Sleep Medicine (2017) recommends that diagnostic testing for OSA be performed in combination with a comprehensive sleep evaluation.[5] Polysomnography is the gold standard test for the diagnosis of OSA in adults in whom there is concern for OSA based on the sleep evaluation. In some cases, and within the appropriate context, the use of home sleep apnea test (HSAT) as the initial sleep study may be acceptable, however, polysomnography should be used when HSAT results do not provide satisfactory posttest probability of confirming or ruling out OSA. In uncomplicated adult patients with signs and

symptoms that indicate an increased risk of moderate to severe OSA, polysomnography or HSAT with a technically adequate device can be used for the diagnosis of OSA. HSAT results are reported as respiratory event index (REI) to represent the frequency of apneas and hypopneas over the total recording time rather than sleep time (as used in the AHI). The thresholds for REI and AHI to define moderate or severe OSA are the same, although it is noted that HSAT may underestimate the true AHI (false negative).

Available treatment guidelines for OSA do not specifically mention the GLP-1 agonists. The American Thoracic Society clinical practice guideline on the role of weight management in the treatment with adults with OSA (2018) recommends that patients with OSA who are overweight or obese (BMI ≥ 25 kg/m^2) participate in comprehensive lifestyle intervention that includes a reduced calorie diet, exercise/increased physical activity, and behavioral counseling.[6] For patients with OSA and a BMI ≥ 27 kg/m^2 who have not had an improvement in weight despite a comprehensive weight-loss lifestyle program, and have no contraindications (no active CV disease), evaluation for anti-obesity medication is suggested. The weight-loss goal in patients with overweight or obesity with OSA should be ≥ 7% to 10% of total body weight. The AACE Consensus Statement: Algorithm for the Evaluation and Treatment of Adults with Obesity/ABCD (2025 update) recommends a weight loss target of 7% to 10% in patients with OSA and ABCD/obesity; > 10% weight loss is noted to results in additional benefit.[3]

Clinical success in OSA has been described by several publications. The American Academy of Sleep Medicine (2019) cites a clinically significant threshold of ≥ 15 events/hour (on AHI)[7] and a clinical practice guideline for the treatment of OSA and snoring with oral appliance therapy (2015) from the American Academy of Sleep Medicine and American Academy of Dental Sleep Medicine[8] notes that treatment success is usually defined as a reduction in the AHI to a specific level (e.g., post-treatment AHI < 5 events/hour, or a > 50% reduction in AHI). Of note, a meta-analysis on the impact of weight reduction on AHI reported that weight reduction in patients with obesity and OSA was associated with improvements in the severity of OSA. A BMI reduction of 20% was associated with an AHI reduction of 57%; further weight reduction beyond 20% in BMI was associated with a smaller effect on AHI.[9]

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Zepbound. All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days.

Zepbound® (tirzepatide subcutaneous injection [KwikPens, pens, and vials] - Eli Lilly) is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indications

1. **Weight Loss in an Adult with Overweight or Obesity.** Approve for the duration noted if the patient meets ONE of the following (A or B):
   - **A)** Initial Therapy. Approve for 8 months if the patient meets ALL of the following (i, ii, iii, and iv):
     - **i.** Patient is ≥ 18 years of age; AND
     - **ii.** Patient has engaged in a trial of behavioral modification and dietary restriction for at least 3 months; AND
     - **iii.** Patient meets ONE of the following (a or b):
       - **a)** At baseline, patient had a BMI ≥ 30 kg/m^2; OR
         Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., liraglutide [Saxenda, generic], Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).
       - **b)** Patient meets BOTH of the following [(1) and (2)]:
         - **(1)** At baseline, patient had a BMI ≥ 27 kg/m^2; AND
         - **(2)** At baseline, patient had, or patient currently has, at least ONE of the following weight-related comorbidities: hypertension, type 2 diabetes, dyslipidemia, obstructive sleep apnea, cardiovascular disease, knee osteoarthritis, asthma, chronic obstructive pulmonary disease, metabolic dysfunction-associated steatotic liver disease/non-alcoholic fatty liver disease, polycystic ovarian syndrome, or coronary artery disease; AND
           Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., liraglutide [Saxenda, generic], Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).
     - **iv.** The medication will be used concomitantly with behavioral modification and a reduced-calorie diet; OR
   - **B)** Patient is Currently Receiving Zepbound. Approve for 1 year if the patient meets ALL of the following (i, ii, iii, and iv):
     Note: For a patient who has not completed 8 months of initial therapy, refer to Initial Therapy criteria above.
     - **i.** Patient is ≥ 18 years of age; AND
     - **ii.** Patient meets ONE of the following (a or b):
       - **a)** At baseline, patient had a BMI ≥ 30 kg/m^2; OR
         Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., liraglutide [Saxenda, generic], Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).
       - **b)** Patient meets BOTH of the following [(1) and (2)]:

(1) At baseline, patient had a BMI ≥ 27 kg/m^2; AND

(2) At baseline, patient had, or patient currently has, at least ONE of the following weight-related comorbidities: hypertension, type 2 diabetes, dyslipidemia, obstructive sleep apnea, cardiovascular disease, knee osteoarthritis, asthma, chronic obstructive pulmonary disease, metabolic dysfunction-associated steatotic liver disease/non-alcoholic fatty liver disease, polycystic ovarian syndrome, or coronary artery disease; AND
Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., liraglutide [Saxenda, generic], Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).

iii. Patient has lost ≥ 5% of baseline body weight; AND
Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., liraglutide [Saxenda, generic], Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).

iv. The medication will be used concomitantly with behavioral modification and a reduced-calorie diet.

2. Obstructive Sleep Apnea, Moderate to Severe, in a Patient with Obesity.
Approve for 1 year if the patient meets ONE of the following (A or B):

A) Initial Therapy. Approve if the patient meets ALL of the following (i, ii, iii, iv, and v):

i. Patient is ≥ 18 years of age; AND

ii. At baseline, patient had a BMI ≥ 30 kg/m^2; AND
Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., liraglutide [Saxenda, generic], Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).

iii. Patient has had a sleep study that shows BOTH of the following (a and b):

a) Patient has been diagnosed with moderate to severe obstructive sleep apnea; AND

b) Patient meets ONE of the following [(1) or (2)]:

(1) Patient has an apnea-hypopnea index ≥ 15 events per hour; OR

(2) Patient has a respiratory event index ≥ 15 events per hour; AND

iv. The patient does NOT meet either of the following (a or b):
Note: A patient who has one or more of the following conditions/diagnoses below is not approved.

a) Central sleep apnea; OR

b) Cheyne Stokes respiration; AND

v. The medication will be used concomitantly with behavioral modification and a reduced-calorie diet; OR

B) Patient is Currently Receiving Zepbound. Approve if the patient meets ALL of the following (i, ii, iii, and iv):
Note: For a patient who has not completed 1 year of initial therapy, refer to Initial Therapy criteria above.

i. Patient is ≥ 18 years of age; AND

ii. At baseline, patient had a BMI ≥ 30 kg/m^2; AND
Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., liraglutide [Saxenda, generic], Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).

iii. Patient has completed ≥ 1 year of therapy with Zepbound AND the patient meets BOTH of the following (a and b):
- **a)** Patient has lost ≥ 10% of baseline body weight; AND
  Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., liraglutide [Saxenda, generic], Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound).
- **b)** According to the prescriber, patient has stability in obstructive sleep apnea signs or symptoms; AND
  Note: Examples of signs or symptoms of obstructive sleep apnea include but are not limited to snoring, excessive daytime sleepiness, fatigue.

iv. The medication will be used concomitantly with behavioral modification and a reduced-calorie diet.

CONDITIONS NOT COVERED

Zepbound® (tirzepatide subcutaneous injection [KwikPens, pens, and vials] - Eli Lilly) is(are) considered not medically necessary for ANY other use(s) including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. **Concomitant Use with Glucagon-Like Peptide-1 (GLP-1) Agonists or GLP-1/Glucose-Dependent Insulinotropic Polypeptide (GIP) Agonists.** Concomitant use of Zepbound with another tirzepatide-containing product or GLP-1 receptor agonist is not recommended.[1]

REFERENCES

1. Zepbound® subcutaneous injection [prescribing information]. Indianapolis, IN: Eli Lilly; February 2026.
2. Malhorta A, Grunstein RR, Fietze I, et al; for the SURMOUNT-OSA Investigators. Tirzepatide for the treatment of obstructive sleep apnea and obesity. *N Engl J Med.* 2024;391(13):1193-1205.
3. Nadolsky K, Garvey WT, Agarwal M, et al. American Association of Clinical Endocrinology consensus statement: algorithm for the evaluation and treatment of adults with obesity/adiposity-based chronic disease — 2025 Update. *Endocrine Practice*. 2025;31:1351–1394.
4. American Diabetes Association Professional Practice Committee for Obesity. Pharmacologic treatment of obesity in adults: Standards of care in overweight and obesity. *DOCM Care.* 13 Jan 2026 [Online ahead of print].

5. Kapur VK, Auckley DH, Chowdhuri S, et al. Clinical practice guideline for diagnostic testing for adult obstructive sleep apnea: an American Academy of Sleep Medicine clinical practice guideline. *J Clin Sleep Med.* 2017;13(3):479-504.
6. Hudgel DW, Patel SR, Ahasic AM, et al; on behalf of the American Thoracic Society Assembly on Sleep and Respiratory Neurology. The role of weight management in the treatment of adult obstructive sleep apnea. *Am J Respir Crit Care Med.* 2018;198(6):e70-e87.
7. Ramar K, Dort LC, Katz SG et al. Clinical practice guideline for the treatment of obstructive sleep apnea and snoring with oral appliance therapy: an update for 2015. An American Academy of Sleep Medicine and American Academy of Dental Sleep Medicine Clinical Practice Guideline. *J Clin Sleep Med.* 2015;11(7):773-827.
8. Patil SP, Ayappa IA, Caples SM, et al. Treatment of adult obstructive sleep apnea with positive airway pressure: An American Academy of Sleem Medicine Systematic Review, Meta-analysis, and GRADE Assessment. *J Clin Sleep Med.* 2019;15(2):301-334.
9. Malhorta A, Heilman CR, Banerjee, et al. Weight reduction and the impact on apnea-hypopnea index: a systematic meta-analysis. *Sleep Medicine.* 2023;121:26-31.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	The Weight Loss – Glucagon-Like Peptide-1 Agonists PA Policy was retired. A new policy was created, the new policy name. **Obstructive Sleep Apnea, Moderate to Severe, in a Patient with Obesity.** The requirement for a sleep study showing moderate to severe obstructive sleep apnea was updated to clarify that the patient must have an apnea-hypopnea index ≥ 15 events/hour or a respiratory event index ≥ 15 events/hour (previously only apnea-hypopnea index). The Note defining moderate and severe obstructive sleep apnea was removed.	06/17/2026