



Updated: 01/2026
Approved: 01/2026

Request for Prior Authorization for Tepezza (teprotumumab-trbw)
Website Form – www.wv.highmarkhealthoptions.com
Submit request via: Fax - 1-833-547-2030.

All requests for Tepezza (teprotumumab-trbw) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Tepezza (teprotumumab-trbw) Prior Authorization Criteria:

For all requests for Tepezza (teprotumumab-trbw) all of the following criteria must be met:

- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
- Must be prescribed by or in consultation with a specialist in ophthalmology or endocrinology

Coverage may be provided with a diagnosis of Thyroid Eye Disease (TED) and the following criteria is met:

- Must be euthyroid or have thyroxine and free triiodothyronine levels less than 50% above or below normal limits
- **Initial Duration of Approval:** Eight infusions
- **Reauthorization criteria**
 - Requests outside 8 total infusions require documentation of peer-reviewed compendia supporting the member's healthcare outcome will be improved by dosing beyond the FDA approved treatment duration.
- **Reauthorization Duration of approval:** up to 8 infusions (dependent on peer-reviewed compendia support provided)

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

TEPEZZA (TEPROTUMUMAB-TRBW) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (833)-547-2030.**

If needed, you may call to speak to a Pharmacy Services Representative. **PHONE: 1-844-325-6251 Mon – Fri 8 am to 7 pm**

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Member ID:	Member weight: Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:
Directions:	Quantity: Refills:
Is the member currently receiving requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No Date Medication Initiated:	
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Billing Information

This medication will be billed: <input type="checkbox"/> at a pharmacy OR <input type="checkbox"/> medically, JCODE:
Place of Service: <input type="checkbox"/> Hospital <input type="checkbox"/> Provider's office <input type="checkbox"/> Member's home <input type="checkbox"/> Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:
Is the member euthyroid or have thyroxine and free triiodothyronine levels less than 50% above or below normal limits? <input type="checkbox"/> Yes <input type="checkbox"/> No	

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date