Updated: 04/2020
DMMA Approved: 04/2020

Request for Prior Authorization for Tepezza (teprotumumab-trbw)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

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

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

- Member is 18 years of age or older.
- Must have a clinical diagnosis of Graves' disease
- Must be euthyroid or have thyroxine and free triiodothyronine levels less than 50% above or below normal limits
- Must have a Clinical Activity Score of greater than or equal to 4
- Onset of TED symptoms is within 9 months of request for treatment
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims if available) or had an intolerance or contraindication to at least one of the following:
    - Intravenous Corticosteroids
    - Rituximab or any of its biosimilars
    - Surgical management
- **Duration of Approval:** Eight infusions

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.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

HIGHMARK. Delaware HEALTH OPTIONS

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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:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

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

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ 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? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: _____ ICD10 Code: _____

Does the member have Graves' Disease? ☐ Yes ☐ No
-If Yes, are they euthyroid or have thyroxine and free triiodothyronine levels less than 50% above or below normal limits? ☐ Yes ☐ No
What is the member's Clinical Activity Score? _____
When was the onset of Thyroid Eye Disease Symptoms? _____/_____/_____
Has the member tried and failed or have a contraindication to surgical management? ☐ Yes ☐ 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