HIGHMARK WHOLECARE

Updated: 10/2026
PARP Approved:09/30/2026

Prior Authorization Criteria

Thyroid Eye Disease Medications

All requests for Thyroid Eye Disease Medications require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Thyroid Eye Disease medications include Tepezza (teprotumumab-trbw) and Lumvoa (veligrotug-vvze). New products with this indication will require the same documentation.

Coverage may be provided with a diagnosis of Thyroid Eye Disease (TED) and the following criteria is 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
- Must not previously been treated with another insulin-like growth factor antagonist (e.g. requests for Tepezza the member must not previously been treated with Lumvoa and for requests for Lumvoa the member must not previously been treated with Tepezza.
- **Duration of Approval:** Eight Infusions for Tepezza; 5 infusions for Lumvoa

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.

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THYROID EYE DISEASE MEDICATIONS
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 Wholecare Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (800) 392-1147 Mon – Fri 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	Provider NPI:
Provider Specialty:	Office Contact:
State license #:	Office NPI:
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? ☐ Yes ☐ No	Date Medication Initiated:	

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, 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:	ICD Code:

Has the member previously tried a different thyroid eye disease medication than the one being requested? ☐ Yes ☐ No *(if yes please list below)*

CURRENT or PREVIOUS THERAPY

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

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date