Prior Authorization Criteria

**Tepezza (teprotumumab-trbw)**

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

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 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 (refer to Table 1)
- 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 intravenous corticosteroids
- **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.

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.

HIGHMARK WHOLECARE

Updated: 03/2022
PARP Approved:03/2022

## TEPEZZA (TEPROTUMAM-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 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: |
|---|---|

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? _____/_____/______

### CURRENT or PREVIOUS THERAPY

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

### SUPPORTING INFORMATION or CLINICAL RATIONALE

| Prescribing Provider Signature | Date |
|---|---|
| | |