HIGHMARK HEALTH OPTIONS

Updated: 04/2025
DMMA Approved: 05/2025

Request for Prior Authorization for Tzield (teplizumab-mzwv)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Tzield (teplizumab-mzwv) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Tzield (teplizumab-mzwv) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of **Type 1 diabetes (T1D)** 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.
- Must be age-appropriate according to FDA-approved labeling, nationally recognized compendia, or evidence-based practice guidelines
- Documentation the member has Stage 2 T1D confirmed by one of the following:
    - At least 2 positive pancreatic islet autoantibodies
        - Glutamic acid decarboxylase 65 (GAD) autoantibodies
        - Insulin autoantibody (IAA)
        - Insulinoma-associated antigen 2 autoantibody (IA-2A)
        - Zinc transporter 8 autoantibody (ZnT8A)
        - Islet cell autoantibody (ICA)
    - Dysglycemia without overt hyperglycemia using an oral glucose tolerance test (if an oral glucose tolerance test is not available, an alternative method for diagnosing dysglycemia without overt hyperglycemia must be documented)
- Documentation Type 2 diabetes has been ruled out based on clinical history
- Documentation the member has had a complete blood count and liver enzyme tests

- **Initial Duration of Approval:** 1 month
- **Reauthorization criteria**
    - None – one time infusion over 14 days

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.

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TZIELD (TEPLIZUMAB-MZWV) 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 Mon – Fri 8:00 am to 7:00 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? ☐ 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, 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:

Please mark all that apply:

1. The members is positive for the following pancreatic autoantibodies
   - ☐ Glutamic acid decarboxylase 65 (GAD) autoantibodies
   - ☐ Insulin autoantibody (IAA)
   - ☐ Insulinoma-associated antigen 2 autoantibody (IA-2A)
   - ☐ Zinc transporter 8 autoantibody (ZnT8A)
   - ☐ Islet cell autoantibody (ICA)

2. The member has dysglycemia without overt hyperglycemia using an oral glucose tolerance test
   ☐ Yes ☐ No (if an oral glucose tolerance test is not available, an alternative method for diagnosing dysglycemia without overt hyperglycemia must be documented)

3. Type 2 diabetes has been ruled out (please submit documentation)
   ☐ Yes ☐ No
4. The member has had a complete blood count and liver enzyme test
   ☐ 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