



**Tziel**  
**Tziel (eplizumab-mzwv) J9381**  
**Prior Authorization Request**  
**Medicare Part B Form**

Instructions: \* Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.

<input type="checkbox"/>	<b>Standard Request– (72 Hours)</b>	<input type="checkbox"/>	<b>Urgent Request</b> (standard time frame could place the member's life, health or ability in serious jeopardy)
Date Requested _____			
Requestor _____ Clinic name: _____ Phone _____ / Fax _____			

**MEMBER INFORMATION**

\*Name: \_\_\_\_\_ \*ID#: \_\_\_\_\_ \*DOB: \_\_\_\_\_

**PRESCRIBER INFORMATION**

\*Name: \_\_\_\_\_  MD  FNP  DO  NP  PA \*Phone: \_\_\_\_\_

\*Address: \_\_\_\_\_ \*Fax: \_\_\_\_\_

**DISPENSING PROVIDER / ADMINISTRATION INFORMATION**

\*Name: \_\_\_\_\_ Phone: \_\_\_\_\_

\*Address: \_\_\_\_\_ Fax: \_\_\_\_\_

**PROCEDURE / PRODUCT INFORMATION**

HCPC Code	Name of Drug	Dose (Wt: _____ kg Ht: _____ )	Frequency	End Date if known

Self-administered       Provider-administered       Home Infusion

Chart notes attached. **Other important information:** \_\_\_\_\_

**Diagnosis: ICD10:** \_\_\_\_\_ **Description:** \_\_\_\_\_

Provider attests the diagnosis provided is an FDA-Approved indication for this drug

**CLINICAL INFORMATION**

**New Start or Initial Request: (Clinical documentation required for all requests)**

**Delay of Onset of Stage 3 Type 1 Diabetes (T1D) in At-Risk Individuals**

- Patient is 8 years or older
- Confirmed diagnosis of Stage 2 type 1 diabetes (presence of two or more islet autoantibodies AND dysglycemia, but asymptomatic)
- No prior diagnosis of Stage 3 type 1 diabetes (symptomatic, requiring insulin)
- Prescribed by or in consultation with endocrinologist
- No active serious infection or immunodeficiency
- No history of hypersensitivity to teplizumab or components
- Patient is not vaccinated with live vaccines within 8 weeks prior to initiation
- Patient is enrolled in and will be monitored through Tziel REMS program (if applicable)

If not, please provide **clinical rationale** for formulary exception: \_\_\_\_\_

**Continuation Requests: (Clinical documentation required for all requests)**

- Patient had an **adequate response** or **significant improvement** while on this medication.
- Medical record documentation of positive response is included

If not, please provide clinical rationale for continuing this medication: \_\_\_\_\_  
\_\_\_\_\_

**ACKNOWLEDGEMENT**

**Request By (Signature Required):** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.** PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

## Prior Authorization Group – Tzielid Prior Authorization

### Drug Name(s):

**TZIELD**

**EPLIZUMAB-MZVV**

### Criteria for approval of Non-Formulary/Preferred Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.
  - If the member meets all these criteria, they may be approved by the Plan for the requested drug.
  - Quantity limits and Tiering will be determined by the Plan, in accordance with the Label.
  - Continuation Requests: Provider must verify continued clinical benefit in clinical documentation.

### Exclusion Criteria:

**N/A**

### Prescriber Restrictions:

**Endocrinologist or other related specialist**

### Coverage Duration:

**Approval will be for 6 months**

### FDA Indications:

**Tzielid**

Diabetes mellitus type 1 stage 3, To delay the onset of Stage 3 type 1 diabetes in patients with Stage 2 type 1 diabetes;  
Prophylaxis

### Off-Label Uses:

**N/A**

### Age Restrictions:

**N/A**

### Other Clinical Consideration:

**N/A**

### Resources:

<https://www.micromedexsolutions.com/micromedex2/librarian/PFDefaultActionId/evidencexpert.DoIntegratedSearch?SearchTerm=Tzielid&SearchFilter=filterNone#>