ATRIO HEALTH PLANS

Thyroid Eye Disease
Tepazza (teprotumumab-trbw) J3241
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.*

☐	**Standard Request– (72 Hours)**	☐	**Urgent Request** (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

☐ **Initial 10 mg/kg IV infusion / Maintenance 20 mg/kg IV infusion - MAX: 8 infusions for 1 course of treatment.**

☐ **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)**

☐ Diagnosis of Moderate to Severe Thyroid Eye Disease and ALL the following:
- ☐ Clinical Activity Score of greater than or equal to 4
- ☐ Proptosis ≥ 3 mm above normal values for race and sex;
- ☐ Intermittent or constant diplopia

☐ Prescribed by, or in consultation with an endocrinologist AND an ophthalmologist;

☐ Patient is euthyroid or has thyroxine and free triiodothyronine levels less than 50% above or below normal limits
TSH/Free T4 Level: _____ Date: _____

☐ Documented Imaging confirmation (CT/MRI showing extraocular muscle enlargement) provided

Criteria continued next page…

☐ Documentation showing the member has tried and failed or had an intolerance or contraindication to at least TWO of the following:

- ☐ Intravenous Corticosteroids
- ☐ Rituximab or any of its biosimilars
- ☐ Surgical management

- **Tepezza (teprotumumab-trbw) may NOT be approved for the following:**
  - More than one course* of treatment; OR
  - Individual is using Tepezza to reduce proptosis for cosmetic reasons alone; OR
  - Individual has had prior orbital irradiation or eye surgery for TED; OR
  - Individual has decreased best-corrected visual acuity due to optic neuropathy as defined by decrease in vision of 2 lines on the Snellen chart, new visual field defect, or color defect; OR
  - Individual has unresponsive corneal decompensation;

Continuation Requests: (Clinical documentation required for all requests)

- **There will be no subsequent continuation after the 8th infusion.**

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 – Thyroid Eye Disease PA

Drug Name(s):
TEPAZZA **TEPROTUMUMAB-TRBW**

Criteria for approval of Prior Authorization 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.

Exclusion Criteria:
N/A

Prescriber Restrictions:
An Endocrinologist AND an Ophthalmologist

Coverage Duration:
Approvals will be for 6 months
Continuation: None

FDA Indications:
Tepazza

- Thyroid eye disease

Off-Label Uses:
N/A

Age Restrictions:
Safety and effectiveness have not been established in pediatric patients

Other Clinical Considerations:
N/A

Resources:
https://www.micromedexsolutions.com/micromedex2/librarian/CS/236DAA/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/42A666/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.GoToDashboard?docId=932815&contentSetId=100&title=Teprotumumab-trbw&servicesTitle=Teprotumumab-trbw&brandName=Tepezza&UserMdxSearchTerm=tepezza&=null#