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

☐ **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 Graves' disease
☐ Clinical Activity Score of greater than or equal to 4
☐ Patient is euthyroid or has thyroxine and free triiodothyronine levels less than 50% above or below normal limits
☐ Presence of moderately to severely active TED, associated with **AT LEAST ONE** of the following:
  ☐ Lid retraction ≥ 2 mm
  ☐ Moderate or severe soft tissue involvement
  ☐ Exophthalmos ≥ 3 mm above normal for race and gender
  ☐ Diplopia
☐ Presence of stable, chronic (inactive) TED, **ONE** of the following:
  ☐ Greater than or equal to 3 mm increase in proptosis from before diagnosis of TED; OR
  ☐ Proptosis ≥ 3 mm above normal values for race and sex

☐ Onset of TED symptoms is within 9 months of request for treatment

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

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

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

☐ Prescribed by, or in consultation with, an oncologist, an endocrinologist or specialist experienced in the treatment of metabolic bone disorders; and

☐ Patient has experienced a positive clinical response to burosumab (e.g., enhanced height velocity, improvement in skeletal deformities, reduction of fractures, reduction of generalized bone pain);

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 – 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:

N/A

Coverage Duration:

Approvals will be for 12 months

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#