



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 $\geq$ 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	
<i>Criteria continued next page...</i>	

- ☐ 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 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#