HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM
TZIELD®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 801-213-1547.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 833-434-4300

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Tzield (teplizumab-mzwv)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the request made by an endocrinologist?	☐	☐	
2. Does the member have a diagnosis of Stage 2, Type 1 Diabetes?	☐	☐	**Please provide documentation**
3. Is the member between the ages of 8-45 years old?	☐	☐	
4. Does the member have an abnormal glucose tolerance by OGTT confirmed within 7 weeks of baseline visit defined by one of the following? a. Fasting blood glucose of 110mg/dL to < 126 mg/dL b. 2-hour post-prandial plasma glucose level ≥ 140mg/dL and < 200mg/dL c. Post-prandial glucose level at 30-, 60-, or 90-minutes ≥ 200mg/dL	☐	☐	**Please provide documentation**
5. Does the member have at least two positive pancreatic islet autoantibodies detected in two samples within 6 months of request?	☐	☐	**Please provide documentation**
6. Does the member have a 1st or 2nd degree relative with Type 1 Diabetes?	☐	☐	**Please provide documentation**
7. Has the member been previously treated with Tzield?	☐	☐	

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician Signature:

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Policy: PHARM-CHIP-M044
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024