HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
TEPEZZA™

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142.

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

If you have prior authorization questions, please call for assistance: University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

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:		HCPCS Code:

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: ☐ Tepezza™ (teprotumumab-trbw)

Dosing/Frequency:_____

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

Questions	Yes	No	Comments/Notes
1. Is the member 18 years of age or older?	☐	☐	
2. Is the prescriber an ophthalmologist?	☐	☐	
3. Does the member have a diagnosis of Graves' disease?	☐	☐	**Please provide documentation**
4. Does the member have a diagnosis of active Thyroid Eye Disease with clinical complications?	☐	☐	**Please provide documentation**
5. Did ocular symptoms begin within 9 months of the baseline assessment?	☐	☐	**Please provide documentation**
6. Is the member's condition moderate to severe as evidenced by one or more of the following: • Lid retraction > 2 mm • Moderate to severe soft-tissue involvement • Proptosis ≥ 3 mm above the normal value for race and sex • Periodic or constant diplopia	☐	☐	**Please provide documentation**
7. Is the member euthyroid?	☐	☐	**Please provide documentation**
8. Does the provider attest that smoking cessation has been addressed with the member?	☐	☐	
9. Has the member had a 1-month trial and failure or contraindication/intolerance to systemic corticosteroids at the maximum tolerated dose?	☐	☐	**Please provide documentation**

10. For members with reproductive potential: Does the provider attest the member is not pregnant and has been informed that appropriate forms of contraception should be implemented prior to initiation, during treatment and for 6 months following the last dose of Tepezza™?	☐	☐	
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-M016
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