

PRIOR AUTHORIZATION REQUEST FORM
TEPEZZA™

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

If you have prior authorization questions, please call Advantage U for assistance: 888-605-0858

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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the prescriber an ophthalmologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the member have a diagnosis of Graves' disease?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Does the member have a diagnosis of active moderate to severe Thyroid Eye Disease with clinical complications? • Low disease activity is excluded	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Did ocular symptoms begin within 9 months of the baseline assessment?	<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
7. Is the member euthyroid?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
8. Does the provider attest that smoking cessation has been addressed with the member?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Has the member had a 1-month trial and failure or contraindication/intolerance to systemic corticosteroids at the maximum tolerated dose?	<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>	

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:			

Policy PHARM-MA-M016
 Origination Date: 01/01/2022
 Reviewed/Revised Date: 05/17/2023
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