OPTIMA HEALTH PLAN

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-844-668-1550.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed.**

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: Tepezza™ (teprotumumab-trbw) **Injection (J3241) (Medical)**
NDC: 75987-0130-15

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **kg**

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Maximum approved dose for thyroid eye disease: IV: 10 mg/kg as a single dose, followed by 20 mg/kg every 3 weeks for 7 additional doses (Max 6 month authorization and Max 8 infusions)

Renewal: None

Part A:

1. Globe protrusion: 13.9mm in Asian males, 16.5mm in white males, 18.5mm in African American males. Adult females have lower exophthalmometry readings than adult males with average of 15.4mm in white women and 17.8mm in African American women

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Length of Approval – 6 months

❑ Member is ≥18 years of age

AND

❑ Prescriber is a specialist in ophthalmology, endocrinology, oculoplastic surgery or neuro-ophthalmology

AND

(Continued on next page)

- ❑ Member has a clinical diagnosis of Thyroid Eye disease that is related to Graves' Orbitopathy

AND

- ❑ Documentation of one (1) of the following:
  - ❑ Lid retraction of ≥2mm
  - ❑ Proptosis of ≥3mm above the normal values for race and sex (see Part A)
  - ❑ exophthalmometer ≥20mm

AND

- ❑ Symptoms began within 12 months of the date of prior authorization form submission

AND

- ❑ Member has a Clinical Activity Score of at least ≥ 4 **(please complete table below)**:

Parameters Assessed	Spontaneous retrobulbar pain	Pain on attempted upward or downward gaze	Eyelid erythema	Eyelid edema	Conjunctival hyperaemia	Conjunctival chemosis	Inflammation of caruncle or plica
Score: Present=1 or Absent=0							
Total:							

AND

- ❑ Member is **NOT** currently smoking and has not smoked within the last 30 days

AND

- ❑ Member must have tried and failed 6 weeks of intravenous methylprednisolone at dose of ≥500mg/week

  Date started: _____

AND

- ❑ Member must have been compliantly taking thyroid medication for the last 3 months and must be euthyroid **OR** has lab levels within the following ranges **(must submit labs completed within the last 30 days)**:
  - ❑ Free triiodothyronine (FT3): 3.5-6.5 pmol/liter OR 230-619 pg/d
  - ❑ Free Thyroxine (FT4): 11.5-22.7 pmol/liter OR 0.7-1.9 ng/dl
  - ❑ Thyrotropin (TSH): 0.55-4.78mIU/liter OR 0.5-6 uU/ml

(Continued on next page; signature page is required to process request.)

(Please ensure signature page is attached to form.)

Medication being provided by: Please check applicable box below.

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy - PropriumRx**

For urgent reviews: Practitioner should call Optima Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Optima's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Member Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 3/19/2020
REVISED/UPDATED: ~~4/8/2020; 11/12/2021 (Reformatted) 7/1/2020;~~ **2/4/2022**