pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

TEPEZZA (teprotumumab) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for Tepezza (teprotumumab) are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/State/Zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested: ☐Tepezza 500 mg vial ☐Tepezza _____	Beneficiary's weight (kg):
Dose/directions: ☐10 mg/kg (_____ mg) for 1st infusion ☐20 mg/kg (_____ mg) every 3 weeks x 7 add'l doses ☐other: _____	# of vials requested: Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):
SPECIALTY PHARMACY DRUG PROGRAM: Tepezza is included in the DHS Specialty Pharmacy Drug Program and is available from DHS's specialty pharmacy. Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Specialty-Pharmacy-Program.aspx for more information about the Specialty Pharmacy Drug Program.	DHS specialty pharmacy: Chartwell Pennsylvania, LP Oakdale, PA Phone: 833-710-0211 Fax: 412-920-1869 www.chartwellpa.com
Is the medication being prescribed by or in consultation with an endocrinologist, ophthalmologist, or ocular surgeon specializing in the treatment of thyroid eye disease?	☐Yes ☐No *Submit documentation of consultation, if applicable.*
Is the beneficiary receiving multidisciplinary treatment that includes consultation with both endocrinology and ophthalmology specialties?	☐Yes ☐No *Submit documentation.*
Does the beneficiary have a diagnosis of active, moderate-severe thyroid eye disease defined by both of the following? *Check all that apply.* ☐Clinical Activity Score of ≥4 (on a scale of 0 to 7) ☐At least one of the following: ☐Lid retraction ≥2 mm ☐Moderate or severe soft tissue involvement ☐Proptosis ≥3 mm above normal values ☐Periodic or constant diplopia	☐Yes ☐No *Submit documentation.*

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Does the beneficiary have results of recent thyroid function tests showing one of the following? ☐ Beneficiary is euthyroid ☐ Beneficiary has mild hypo- or hyperthyroidism (free T3 and free T4 serum levels <50% above or below normal limits)	☐ Yes ☐ No *Submit documentation.*
Does the beneficiary have a history of trial and failure of or contraindication or intolerance to a systemic corticosteroid?	☐ Yes ☐ No *Submit documentation.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date: