



Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/complecare-forproviders/pharmacy

Tepezza Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information					
Member Name (first & last):	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Height:	
Member ID:	City:	State:		Weight:	
Prescribing Provider Information					
Provider Name (first & last):	Specialty:	NPI#	DEA#		
Office Address:	City:	State:		Zip Code:	
Office Contact:		Office Phone		Office Fax:	
Dispensing Pharmacy Information					
Pharmacy Name:		Pharmacy Phone:		Pharmacy Fax:	
Requested Medication Information					
What medication(s) has member tried and failed for this diagnosis? Please specify:					
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): Yes No		Diagnosis:		ICD-10 Code:	
Are there any contraindications to formulary medications? If yes, please specify:				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Directions for Use:		Strength:		Dosage Form:	
		Quantity:	Day Supply:	Duration of Therapy/Use:	
Turn-Around Time for Review					
<input type="checkbox"/> Standard – (24 hours)		<input type="checkbox"/> Urgent – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____			
Clinical Information					
Member has one of the following diagnosis:		<input type="checkbox"/> Moderate to severe Graves' orbitopathy (ophthalmopathy)		<input type="checkbox"/> Thyroid-associated ophthalmopathy (thyroid eye disease (TED))	
Was there T/F with glucocorticoids? (cumulative dose <1000mg methylprednisolone OR equivalent)		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are glucocorticoids C/I or cannot be tolerated?	
Was member on a high dose (> 1000mg methylprednisolone OR equivalent) steroid therapy in the past 4 weeks?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there documentation of baseline testing for all of the following:		<input type="checkbox"/> Proptosis			
		<input type="checkbox"/> Clinical Activity Score of greater than or equal to 4			
		<input type="checkbox"/> Diplopia			
		<input type="checkbox"/> Graves' ophthalmopathy-specific quality-of-life (GO-QOL) questionnaire			
Does member require immediate surgical ophthalmological intervention?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there a plan for corrective surgery/irradiation?	
				<input type="checkbox"/> Yes	<input type="checkbox"/> No

Is there documentation the member is:	<input type="checkbox"/> Euthyroid
	<input type="checkbox"/> Mildly hypo/hyper-thyroid with free thyroxine (FT4)
	<input type="checkbox"/> Free triiodothyronine (FT3) levels less than 50% above or below normal limits

Will provider monitor for elevated Blood Glucose and symptoms of hyperglycemia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Will a female of reproductive potential be using effective contraception prior to starting therapy, during treatment, and for 6 months following last dose of Tepezza?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
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Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required. Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.