**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/chp-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:<br>☐ Male ☐ 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?<br>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?<br>If yes, please specify: | | | ☐ Yes | ☐ No |
| Directions for Use: | Strength: | | Dosage Form: | |
| | Quantity: | Day Supply: | Duration of Therapy/Use: | |

| **Turn-Around Time for Review** | |
|---|---|
| ☐ Standard – (24 hours) | ☐ **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.<br>Signature: ________________________________ |

| **Clinical Information** | | | | | |
|---|---|---|---|---|---|
| Member has one of the following diagnosis: | ☐ Moderate to severe Graves' orbitopathy (ophthalmopathy) | | ☐ Thyroid-associated ophthalmopathy (thyroid eye disease (TED)) | | |
| Was there T/F with glucocorticoids? (cumulative dose <1000mg methylprednisolone OR equivalent) | ☐ Yes | ☐ No | Are glucocorticoids C/I or cannot be tolerated? | ☐ Yes | ☐ No |
| Was member on a high dose (> 1000mg methylprednisolone OR equivalent) steroid therapy in the past 4 weeks? | | | | ☐ Yes | ☐ No |
| Is there documentation of baseline testing for all of the following: | ☐ Proptosis | | | | |
| | ☐ Clinical Activity Score of greater than or equal to 4 | | | | |
| | ☐ Diplopia | | | | |
| | ☐ Graves' ophthalmopathy-specific quality-of-live (GO-QOL) questionnaire | | | | |
| Does member require immediate surgical ophthalmological intervention? | ☐ Yes | ☐ No | Is there a plan for corrective surgery/irradiation? | ☐ Yes | ☐ No |

| Is there documentation the member is: | ☐ Euthyroid |
|---|---|
| | ☐ Mildly hypo/hyper-thyroid with free thyroxine (FT4) |
| | ☐ Free triiodothyronine (FT3) levels less than 50% above or below normal limits |

| Will provider monitor for elevated Blood Glucose and symptoms of hyperglycemia? | ☐ Yes | ☐ 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? | ☐ Yes | ☐ No | ☐ N/A |
|---|---|---|---|---|---|---|

| **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 833-711-0776 to check the status of a request.