JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Tepezza

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:

Strength/Measure _____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

Directions(sig) _____ *Route of administration* _____

Dosing frequency _____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. JHHC Tepezza SGM 3511-A – 07/2023.

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com

Criteria Questions:

What is the ICD-10 code? _____

1. What is the diagnosis?

❒ Thyroid eye disease (TED) (*If checked, go to 2*)
❒ Other, please specify. _____ (*If checked, go to 2*)

2. Is the requested medication being prescribed by or in consultation with an ophthalmologist?
❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

3. Has the patient previously received treatment with the requested medication?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. Does the patient have moderate-to-severe disease? ***ACTION REQUIRED***: Please attach disease severity assessment or supporting chart note(s).
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Does the patient have active or inactive disease?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Which of the following applies to the patient?

❒ Lid retraction greater than or equal to 2 mm (*If checked, go to 7*)
❒ Moderate or severe soft-tissue involvement (*If checked, go to 7*)
❒ Exophthalmos greater than or equal to 3 mm above normal for race and gender (*If checked, go to 7*)
❒ Inconstant or constant diplopia (*If checked, go to 7*)
❒ None of the above (*If checked, go to 7)*

7. Is the patient 18 years of age or older?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Does the patient exceed a one-time treatment course consisting of 8 infusions given once every 3 weeks (e.g., 10mg/kg on first infusion, followed by 20mg/kg every 3 weeks for 7 additional infusions)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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