Tzield (teplizumab-mzwv)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: *(at least one of the following criteria must be met)*

- ❑ Medication being prescribed by, or in consultation with, an endocrinologist to delay onset of stage 3 type 1 diabetes (clinical type 1 diabetes)
- ❑ Patient is 8-45 years of age and DOES NOT have stage 3 type 1 diabetes or type 2 diabetes
- ❑ Patient is not pregnant
- ❑ Confirmed diagnosis of stage 2 type 1 diabetes by documenting (***ALL of the following***):
    - Presence of 2 or more pancreatic islet autoantibodies
    - Patient has a relative with Type 1 diabetes:
        - If first degree relative (brother, sister, parent, offspring), patient must be between 8-45 years old **OR**
        - If second degree relative (niece, nephew, aunt, uncle, grandchild, cousin), patient must be between 8-20 years old
    - Presymptomatic (no overt symptoms of hyperglycemia)
    - Impaired glycemic response (2-h PG 140-199 mg/dL) to an oral glucose tolerance test within the last 3 months
        - If an oral glucose tolerance test is not available, an alternate method for diagnosing dysglycemia without overt hyperglycemia may be appropriate such as FPG 100-125 mg/dL or A1C 5.7-6.4%

        Chart Note Page #: _____

- ❑ Patient has not been previously treated with Tzield (teplizumab-mzwv)
- ❑ Treating provider will obtain a complete blood count and liver enzyme tests prior to/and during treatment as recommended by the Teplizumab prescribing information
- ❑ Treating provider documents administration of all age-appropriate vaccinations prior to/after treatment as recommended by the Teplizumab prescribing information
- ❑ Treating provider attests to counseling the patient regarding the need to complete 14 consecutive days of infusions without missing a dose

Anticipated treatment start date: _____

Authorization: Teplizumab to be administered by intravenous infusion once daily for 14 consecutive days according to the recommended dosage and administration schedule in the prescribing information. One treatment per lifetime
Re-authorization: None

Note:

- ❖ Use appropriate HCPCS code for billing

  Coverage and Reimbursement code look up:
  https://health.utah.gov/stplan/lookup/CoverageLookup.php

  HCPCS NDC Crosswalk: **https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php**

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____
Prescriber's Signature Date