Field Name	Field Description
Prior Authorization Group Description	**Insulin-Like Growth Factor-1 Receptor (Igf-1r) Antagonists For Thyroid Eye Disease**
Drugs	Tepezza (teprotumumab-trbw)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Member must be 18 years age or older
Prescriber Restrictions	Prescriber must be an ophthalmologist, endocrinologist, or specialist with expertise in the treatment of Grave's disease with thyroid eye disease.
Coverage Duration	If all of the criteria are met, the request will be approved for up to 24 weeks of treatment (8 total infusions). Retreatment requests will not be allowed beyond the 8 dose limit.

Other Criteria	****Drug is being requested through the member's medical benefit****
	
	<u>Initial Authorization:</u>
	
	Tepezza is approved when all of the following are met:
	• Dosing does not exceed dosing guidelines as outlined in the package insert
	• Patient has a confirmed diagnosis of Graves' disease
	• Documentation of ~~active~~ moderate-severe thyroid eye disease as evidenced by one or more of the following:
	  o Lid retraction of >2mm
	  o Moderate or severe soft-tissue involvement
	  o Proptosis ≥3mm above normal values for race and sex
	  o Periodic or constant diplopia
	• ~~Patients Clinical Activity Score must be ≥4 (must be submitted with request)~~
	• Patient must be euthyroid or thyroxine and free triiodothyronine levels are less than 50% above or below normal limits (submit laboratory results with request)
	• Patients of reproductive potential: attestation the patient is not pregnant, and appropriate contraception methods will be

Revision/Review Date ~~5/2022~~ **7/2023**	used before, during, and 6 months after the last infusion • Patient has had a trial and therapy failure of, or contraindication to: o **For active disease:** oral or IV glucocorticoids~~to treat their condition~~ o **For chronic/inactive disease: rehabilitative surgery** **Re-authorization:** • Retreatment or renewal requests beyond a total of 24 weeks of treatment (8 total infusions) will not be allowed. **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**