



Tepezza® (teprotumumab-trbw) Medication Precertification Request

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(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification

Phone: **1-866-752-7021 (TTY: 711)**

FAX: **1-888-267-3277**

For Medicare Advantage Part B:

Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____ / ____ / ____
☐ Continuation of therapy, Date of last treatment ____ / ____ / ____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:		Last Name:		DOB:	
Address:			City:	State:	ZIP:
Home Phone:	Work Phone:		Cell Phone:	Email:	
Patient Current Weight: ____ lbs or ____ kgs			Patient Height: ____ inches or ____ cms		Allergies:

B. INSURANCE INFORMATION

Aetna Member ID #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: (Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.			
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty (Check one): ☐ Ophthalmologist ☐ Other: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	Dispensing Provider/Pharmacy: Patient Selected choice <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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E. PRODUCT INFORMATION

Request is for: Tepezza (teprotumumab-trbw) Dose: _____ Frequency: _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required for all requests):

☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?

☐ Yes ☐ No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?

☐ Yes ☐ No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?

☐ Yes ☐ No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?

☐ Yes ☐ No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the patient's ability to tolerate a large volume or load or predispose the patient to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?

☐ Yes ☐ No Please provide a description of the condition: _____

☐ Cardiopulmonary: _____

☐ Respiratory: _____

☐ Renal: _____

☐ Other: _____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION – (continued) Required clinical information must be completed in its entirety for all precertification requests.

- ☐ Yes ☐ No Has the patient been diagnosed with thyroid eye disease (TED)?
- ☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with an ophthalmologist?
- ☐ Yes ☐ No Does the patient have moderate-to-severe disease?
- ☐ Yes ☐ No Does the patient have active or inactive disease?

Which of the following applies to the patient?

- ☐ Lid retraction ≥ 2 mm
- ☐ Moderate or severe soft-tissue involvement
- ☐ Exophthalmos ≥ 3 mm above normal for race and gender
- ☐ Inconstant or constant diplopia
- ☐ None of the above
- ☐ Yes ☐ No 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)?

H. ACKNOWLEDGEMENT

Request Completed By (Signature Required): _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.