UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

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: *(all 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 at least 8 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:
    - Presence of 2 or more pancreatic islet autoantibodies
    - Presymptomatic (no overt symptoms of hyperglycemia)
    - Impaired glycemic response (2-h PG 140-199 mg/dL) to an oral glucose tolerance test
        - 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% within the last 3 months.

  Chart Note Page #: _____
- ❑ 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 will administer 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.

Initial 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.
Re-authorization: Not applicable

PROVIDER CERTIFICATION

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

_____ _____

Prescriber's Signature Date