OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare Tzield™ (Teplizumab-mzwv) Prior Authorization Form

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Member Name:_______________________ Date of Birth:______________ Member ID#:________________

Drug Information

☐**Physician billing (HCPCS code:____________)** ☐**Pharmacy billing (NDC:_______________________)**

Dose:________________ Regimen:___________________ Start Date (or date of next dose):____________

Billing Provider Information

Provider NPI:____________________________ Provider Name:___________________________________

Provider Phone:____________________________ Provider Fax:__________________________________

Prescriber Information

Prescriber NPI:_______________________ Prescriber Name:_____________________________________

Prescriber Phone:_______________ Prescriber Fax:________________ Specialty:__________________

Criteria

Page 1 of 2— Please complete and return all pages. Failure to complete all pages will result in processing delays.

For Authorization: *Approvals will be for (1) 14-day cycle per member per lifetime.*

1. Please indicate the diagnosis and information:
   ☐ Stage 2 Type 1 Diabetes Mellitus (DM)
   ☐ Other ____________________________
2. Has the member had laboratory testing confirming the presence of ≥2 pancreatic islet antibodies?
   Yes ☐ No ☐
   a. If yes, please submit documentation with results of autoantibody testing.
3. Does member have evidence of dysglycemia without overt hyperglycemia as demonstrated by an abnormal oral glucose test (OGTT)? Yes ☐ No ☐
   a. If yes, please provide documentation of the following:
      i. Fasting plasma glucose: _____________
      ii. 2-hour plasma glucose: ______________
      iii. 30-, 60-, or 90-minute value on OGTT: ______________
4. Does the member's clinical history suggest a diagnosis of Type 2 DM? Yes ☐ No ☐
5. Was teplizumab prescribed by an endocrinologist, or an advanced care practitioner with a supervising physician who is an endocrinologist? Yes ☐ No ☐
6. If member is female and of reproductive potential;
   a. Is the member pregnant? Yes ☐ No ☐
   b. Is the member using reliable contraception? Yes ☐ No ☐
7. Does the member have any active infections? Yes ☐ No ☐
8. Please provide complete blood counts (CBC): ____
   a. Are the levels acceptable to the prescriber? Yes ☐ No ☐
9. Please provide liver function tests: ____
   a. Are the levels acceptable to the prescriber? Yes ☐ No ☐
10. Have all age-appropriate vaccinations been administered prior to treatment? Yes ☐ No ☐
11. Does prescriber agree to premedicate the member for the first 5 days of dosing, and as needed with a non-steroidal anti-inflammatory drug (NSAID) or acetaminophen, an antihistamine, and/or an antiemetic?
    Yes ☐ No ☐

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorizationthrough CoverMyMeds® or SureScripts.All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**

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***Member Name:*______________________ *Date of Birth:*______________ *Member ID#:*_______________**

Criteria

For Authorization *(continued)*

12. Will teplizumab be administered by a health care professional? Yes ☐ No ☐
    a. For facility administration, will teplizumab be shipped via cold chain supply to the facility where the member is scheduled to receive treatment? Yes ☐ No ☐
    b. For home administration, will teplizumab be shipped via cold chain supply to the member's home and administered by a home health care provider, and the member or member's caregiver be trained on the proper storage? Yes ☐ No ☐
13. Member's body surface area (BSA): ______________ Date taken: ________________

Additional information: ____

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Prescriber Signature:________________________________ Date:____________________________

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

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