# AvMed

## MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

**Directions:** **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-877-535-1391**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

**For Medicare Members:** Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

## Drug Requested: Tzield™ (teplizumab) (J3590/C9399) (Medical)

**MEMBER & PRESCRIBER INFORMATION:** Authorization may be delayed if incomplete.

**Member Name:** _____

**Member AvMed #:** _____ **Date of Birth:** _____

**Prescriber Name:** _____

**Prescriber Signature:** _____ **Date:** _____

**Office Contact Name:** _____

**Phone Number:** _____ **Fax Number:** _____

**DEA OR NPI #:** _____

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

**Drug Form/Strength:** _____

**Dosing Schedule**: _____ **Length of Therapy**: _____

**Diagnosis:** _____ **ICD Code, if applicable:** _____

**Weight:** _____ **Height:** _____ **BSA:** _____ **Date:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

## Recommended Dosage:

- Administered intravenously over at least 30 minutes daily for 14-day course
  - Day 1: 65 mcg/$m^2$
  - Day 2: 125 mcg/$m^2$
  - Day 3: 250 mcg/$m^2$
  - Day 4: 500 mcg/$m^2$
  - Days 5 through 14: 1,030 mcg/$m^2$
- Premedicate prior to infusion on days 1-5 dosing: (1) nonsteroidal anti-inflammatory drug (NSAID) or acetaminophen, (2) an antihistamine, and/or (3) an antiemetic. Additional doses may be administered if needed.

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## Quantity Limits:

- 1 single dose vial daily for 14 days

**CLINICAL CRITERIA:** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

**Coverage will be provided for one 14-day treatment course and may not be renewed.**

- ❑ Member is ≥ 8 years of age
- ❑ Prescribed by or in consultation with an endocrinologist
- ❑ Member has a confirmed diagnosis of Stage 2 Type 1 Diabetes as documented by **BOTH** of the following:
  - ❑ Member has at least **TWO** of the following pancreatic islet cell autoantibodies:
    - ❑ Glutamic acid decarboxylase 65 (GAD) autoantibodies
    - ❑ Insulin autoantibody (IAA)
    - ❑ Insulinoma-associated antigen 2 autoantibody (IA-2A)
    - ❑ Zinc transporter 8 autoantibody (ZnT8A)
    - ❑ Islet cell autoantibody (ICA)
  - ❑ Dysglycemia without overt hyperglycemia using oral glucose test defined by **ONE** of the following as:
    - ❑ Fasting glucose 100-125 mg/dL
    - ❑ 2-hour postprandial plasma glucose 140-199 mg/dL
    - ❑ An intervening postprandial glucose level at 30, 60, or 90 minutes of ≥ 200 mg/dL
- ❑ Member does **NOT** have Stage 1 or Stage 3 Type 1 Diabetes
- ❑ Member does **NOT** have Type 2 Diabetes
- ❑ Member has **NOT** received a prior course of teplizumab (Tzield™) or donislecel (Lantidra™)
- ❑ Member is up to date with all vaccinations prior to initiating therapy
- ❑ Member will **NOT** receive live or live-attenuated vaccines within 8 weeks **OR** inactivated or mRNA vaccines within 2 weeks before or during treatment
- ❑ Member does **NOT** have an active infection
- ❑ Member has been evaluated for acute infection with Epstein-Barr virus (EBV) or cytomegalovirus (CMV)

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- ❑ Member does **NOT** have any of the following:
  - Lymphocyte count < 1,000 lymphocytes/mcL
  - Hemoglobin < 10 g/dL
  - Platelet count < 150,000 platelet/mcL
  - Absolute neutrophil count < 1,500 neutrophils/mcL
  - Elevated ALT or AST > 2 times the upper limit of normal (ULN)
  - Bilirubin > 1.5 times ULN
- ❑ Requested medication will be used as single agent therapy

**Medication being provided by: Please check applicable box below.**

- ❑ **Location/site of drug administration:** _____

  **NPI or DEA # of administering location:** _____

**OR**

- ❑ **Specialty Pharmacy – Proprium Rx**

For urgent reviews: Practitioner should call AvMed Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****