Blue Cross Blue Shield Blue Care Network of Michigan

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Blue Cross Medicare Plus Blue℠ PPO and BCN Advantage℠ Medication Authorization Request Form Tepezza™ (teprotumumab-trbw) J3590

The most efficient way to request authorization is to use the NovoLogix® system. To access NovoLogix, visit bcbsm.com/providers and log in to Provider Secured Services. Click the link for Medical Prior Authorization. As an alternative, you can use this form to request authorization. Complete this form and fax to 1-866-392-6465. If you have any questions regarding this process, contact the Pharmacy Clinical Help Desk at 1-800-437-3803.

PATIENT INFORMATION	PHYSICIAN INFORMATION
Name	**Name**
ID Number	**Specialty**
Date of birth ☐Male ☐Female	**Address**
Diagnosis (include ICD-10)	**City /State/Zip**
Drug Name	**Phone:** ( ) - **Fax:** ( ) -
Dose and Quantity	**NPI**
Directions	**Contact Person**
Date of Services	**Contact Person's Phone / Ext.**

STEP 1: DISEASE STATE INFORMATION

1. Is this request for initiation or continuation of Tepezza™?

   ☐ Initiation ☐ Continuation. Start date of therapy. _____

2. Is the patient being seen by or in consultation with an endocrinologist or ophthalmologist?

   ☐ Yes ☐ No. Please provide physician's specialty_____

3. What is the patient's diagnosis? ☐ Thyroid Eye Disease ☐ Other. Please list indication_____

4. What symptoms did the patient have regarding moderate to severe active thyroid eye disease? (select all that apply)

   ☐ Decrease in color vision
   ☐ Moderate or severe soft tissue involvement
   ☐ Exophthalmos greater than or equal to 3mm above normal for race and gender
   ☐ Inconstant or constant diplopia
   ☐ Other. Please specify the condition the patient has. _____

5. What is the Clinical Activity Score (CAS) in the most severely affected eye? _____

6. Has the patient tried oral or intravenous steroids?

   ☐ Yes. Please list the name and dosage of steroid the patient tried. _____ ☐ No

7. Please attach any chart notes or additional documentation and submit to plan. ***(Required)***

Coverage won't be provided if the prescribing physician's signature and date aren't reflected on this document.

☐ Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

Physician's Name **Physician's Signature** **Date**

Step 2: Checklist	☐ Form Completely Filled Out ☐ Attached Chart Notes	☐ Concurrent Medical Problems ☐ Prior Therapies
Step 3: Submit	**Fax the completed form to 1-866-392-6465**	