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

***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 ☐



| PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO: | CONFIDENTIALITY NOTICE |
|---|---|
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# State of Oklahoma
# SoonerCare
# Tzield™ (Teplizumab-mzwv) Prior Authorization Form

***Member Name:*** _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

## Criteria

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

**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: _____

_____

_____

_____

_____

_____

***(Page 2 of 2)***

**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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