HUSKY Health Program Tepezza®
Prior Authorization Request Form
Phone: 1.800.440.5071

THIS FORM IS TO BE COMPLETED BY THE ORDERING PROVIDER AND FAXED WITH CLINICAL DOCUMENTATION TO 203.265.3994

Member Information			
Date of First Dose:	Member ID #:		Member Name (Last, First):
Address:			City, State, Zip:
DOB:	Age:	Sex:	Primary Diagnosis Code:
HCPCS Code:	Total Number of Doses:	Number of Units per Dose (Note: units based on HCPCS code description):	Total Number of Units for Authorization Period (Number of Units per Dose X Total Number of Doses):

Please Fill Out Completely		
1. Is the individual 18 years of age or older?	○ Yes	○ No
2. Does the individual have thyroid eye disease (TED)?	○ Yes	○ No
3. Is Tepezza® (teprotumumab-trbw) prescribed by, or in consultation with, an ophthalmologist?	○ Yes	○ No
4. Has the individual previously completed a full course of treatment with Tepezza® (teprotumumab-trbw)?	○ Yes	○ No
5. Will the administration follow the current FDA approved labeling and dosing protocol for Tepezza® (teprotumumab-trbw)?	○ Yes	○ No

Note: Review criteria are used as guidelines only. Determinations are based on a person-centered assessment of the individual and their unique clinical needs. Additional information submitted with this request will be considered as part of the medical necessity review process, in accordance with Conn. Gen. Stat. Sec. 17b-259b.

Billing Provider Information		
Medicaid Billing Number:		Billing Provider Name:
Street Address:		City, State, Zip:
Contact Name:	Contact Telephone Number:	Contact Fax Number:

Ordering Provider Information		
Medicaid Billing Number:		Ordering Provider Name:
Street Address:		City, State, Zip:
Contact Name:	Contact Telephone Number:	Contact Fax Number:

Certification Statement: This is to certify that the requested medication is medically indicated and is reasonable and necessary for the treatment of this patient, and that a prescribing practitioner signed order is on file. This form and any statement on my letterhead attached hereto has been completed by me or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil and criminal liability.

Physician Signature:	**Date:**