JOHNS HOPKINS MEDICINE / JOHNS HOPKINS HEALTHCARE	Johns Hopkins HealthCare LLC **Pharmacy Public** **Medical Management Drug Policies**	*Policy Number*	MMDP061
		Effective Date	06/01/2022
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	Subject **Tepezza**	*Revision Date*	04/20/2022
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This document applies to the following Participating Organizations:

US Family Health Plan

Keywords: Tepezza

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I. POLICY

A. Tepezza (teprotumumab-trbw) will require prior authorization for medical benefit coverage to ensure appropriate use. The process for initiating a prior authorization request can be found in policy PHARM 20.

II. POLICY CRITERIA

A. Tepezza may be approved for patients who meet the following:
   1. Patient is 18 years of age or older
   2. Documentation has been submitted showing the following:
      a. Patient has a diagnosis of Thyroid Eye Disease
      b. Patient has active disease with a clinical activity score (CAS) greater than or equal to 4, based an assessment of the following elements (presence of an element equates one point):
         I. Painful feeling behind the globe over last 4 weeks
         II. Pain with eye movement during last 4 weeks
         III. Redness of the eyelids
         IV. Redness of the conjunctiva
         V. Swelling of the eyelids
         VI. Chemosis (edema of the conjunctiva)
         VII. Swollen caruncle (flesh body at medial angle of eye)
      c. Patient has moderate-to-severe disease, evidenced by one of the following;
         I. Lid retraction #2 mm
         II. Moderate or severe soft-tissue involvement
         III. Exophthalmos #3 mm above normal for race and gender
         IV. Inconstant or constant diplopia
   3. Prescriber is, or has consulted with, an ophthalmologist

III. AUTHORIZATION PERIOD/LIMITATIONS

A. Approval will be limited to a one-time 6 months of therapy to allow for 8 infusions total

IV. EXCLUSIONS

A. Tepezza will not be covered for the following:
   1. Repeat series of infusions
   2. Any indications or uses that are not FDA-approved, or guideline-supported

V. RECOMMENDED DOSAGE

Please refer to the FDA-approved prescribing information for indication-specific dosing details.

VI. CODES

Note: The following CPT/HCPCS codes are included below for informational purposes. Inclusion or exclusion of a CPT/ HCPCS code(s) below does not signify or imply member coverage or provider reimbursement. The member's specific benefit plan determines coverage.

Medication	HCPCS/Code
Injection, teprotumumab-trbw, 10 mg	J3241

VII. REFERENCES

1. Tepezza [prescribing information]. Dublin, Ireland: Horizon Therapeutics Ireland DAC; October 2021.
2. Bartalena L, Baldeschi L, Kostas B, et al. The 2016 European Thyroid Association/European Group on Graves' Orbitopathy guidelines for the management of Graves' orbitopathy. Eur Thyroid. 2016;5(1):9-26.
3. Ross DS, Burch HB, Cooper DS, et al. 2016 American Thyroid Association guidelines for diagnosis and management of hyperthyroidism and other causes of thyrotoxicosis. Thyroid. 2016;26(10):1343-1421.

VIII. APPROVALS

Signature on file at JHHC

DATE OF REVISION	SUMMARY OF CHANGE
04/20/2022	Policy Creation

Reveiw Dates: 04/20/2022

Revision Dates: