Tzield™ (teplizumab-mzwv) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: ______________________ Phone: ____________ Fax: ____________

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:
Address:	City:	State: ZIP:
Home Phone: Work Phone:	Cell Phone:	Email:
Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms	Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: ______________	Does patient have other coverage? ☐ Yes ☐ No
Group #: ______________	If yes, provide ID#: ____________ Carrier Name: ______________
Insured:	Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:	Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.		
Address:	City:	State:	ZIP:
Phone: Fax:	St Lic #: NPI #:	DEA #:	UPIN:
Provider Email:	Office Contact Name:	Phone:	

Specialty *(Check one)*: ☐ **Endocrinologist** ☐ **Other**: ______________________

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: ______________
Center Name: ______________
☐ Home Infusion Center Phone: ______________
Agency Name: ______________
☐ Administration code(s) (CPT): ______________
Address: ______________

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other
Name: ______________
Address: ______________
Phone: ______________ Fax: ______________
TIN: ______________ PIN: ______________

E. PRODUCT INFORMATION

Request is for TZIELD (teplizumab-mzwv): Dose: ______________ **Frequency:** ______________

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: ______________ **Secondary ICD Code:** ______________ **Other ICD Code:** ______________

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required):

☐ Yes ☐ No Does the patient have a diagnosis of stage 2 type 1 diabetes?
☐ Yes ☐ No Is this request to delay the onset of stage 3 type 1 diabetes?
☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with an endocrinologist?
☐ Yes ☐ No Does the patient have 2 or more of the following pancreatic islet cell autoantibodies detected in two samples obtained within the past 6 months?
→ ☐ 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)
☐ Yes ☐ No Does the patient have an abnormal oral glucose tolerance test (OGTT) confirming dysglycemia within the past 2 months?
☐ Yes ☐ No Does the patient have a fasting blood glucose level of 110 to 125 mg/dL (6.1 to 6.9 mmol/L)?
☐ Yes ☐ No Does the patient have a 2-hour postprandial plasma glucose level of at least 140 mg/dL (7.8 mmol/L) and less than 200 mg/dL (11.1 mmol/L)?
☐ Yes ☐ No Was the intervening postprandial glucose level at 30, 60, or 90 minutes of greater than 200 mg per deciliter (11.1 mmol/L) on two or more occasions?
☐ Yes ☐ No Does the patient have symptoms associated with type 1 diabetes (e.g., increased urination, excessive thirst, weight loss)?
☐ Yes ☐ No Will the patient exceed a one-time 14-day treatment course consisting of the following dosing schedule? (*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)

H. ACKNOWLEDGEMENT

Request Completed By ***(Signature Required):*** ______________________ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.