CareSource Rxinnovations

INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
TZIELD PRIOR AUTHORIZATION REQUEST FORM

CareSource Pharmacy Prior Authorization Form
P.O. Box 8738
Dayton, OH 45401-8738
Fax: (866) 930-0019

Today's Date ☐☐ / ☐☐ / ☐☐☐☐ Non-Urgent ☐ Urgent ☐

Note: This form must be completed by the prescribing provider.

*****All sections must be completed or the request will be returned.*****

Patient's CareSource # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Office Contact
Prescriber's Fax ☐☐☐ - ☐☐☐ - ☐☐☐☐	Prescriber's Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐
Prescriber's Address	Date(s) of Service: _____ Start Date: _____

Requested Medication	Quantity	Directions for Use	Treatment Duration

***Note: Approvals will be granted for ONE 14-day treatment course per lifetime to be utilized within 30 days from the approval date**

TZIELD (TEPLIZUMAB-MZWV)

Please attest to/provide all of the following:

- ☐ Member is 8 years of age or older
- ☐ Member has diagnosis of Stage 2 type 1 diabetes (T1D) Diagnosis Code:_____
- ☐ Submit documentation supporting that the member is positive for at least TWO of the following pancreatic islet cell autoantibodies:
  - Glutamic acid decarbosylase 65 (GAD) autoantibodies
  - Insulin autoantibody (IAA)
  - Insulinoma-associated antigen 2 autoantibody (IA-2A)
  - Zinc transporter 8 autoantibody (ZnT8A)
  - Islet cell autoantibody (ICA)
- ☐ Submit documentation of an oral glucose tolerance test (OGTT) or other acceptable method supporting the member has dysglycemia without overt hyperglycemia
- ☐ Prescriber attests that member's medical history does not suggest type 2 diabetes (T2D) ☐YES ☐NO
- ☐ Submit documentation of complete blood count (CBC) and liver enzyme tests within the past 30 days
- ☐ Submit documentation of a negative pregnancy test within the past 30 days

I attest that the information is accurate:

Physician Signature: _____ Date: _____