**Generic Name:** teprotumumab-trbw, veligrotug-vvze

**Therapeutic Class or Brand Name:** Thyroid Eye Disease

**Applicable Drugs:** Lumvoa (veligrotug-vvze), Tepezza (teprotumumab-trbw).

**Preferred:** N/A

**Non-preferred:** N/A

**Date of Origin:** 8/11/2026

**Date Last Reviewed / Revised:** 8/20/2026

## PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I to V are met)

I. Documented diagnosis of Thyroid Eye Disease (TED) and must meet all the criteria listed under A or B:

A. Moderate-to-severe active TED and meets criterion listed below:

i. Documentation of CAS (Clinical Activity Score) 3 or greater (refer to Appendix Table 1).

ii. Documentation of non-sight threatening disease with appreciable impact on daily life.

iii. Documentation meeting one of the following (1-4):

1. Eyelid retraction 2 mm or greater.
2. Moderate to severe soft tissue involvement.
3. Proptosis 3 mm or greater above normal for race and sex (refer to Appendix Table 2).
4. Diplopia (Gorman score 2 to 3) (refer to Appendix Table 3).

iv. Documented trial or contraindication to intravenous glucocorticoids (IVGC) when significant proptosis or diplopia are absent.

B. Moderate-to-severe stable, chronic, inactive, TED and meets criterion listed below:

i. Documentation of stable ocular symptoms without progression or new inflammation for at least 1 year which are consistent with chronic stable inactive TED (e.g., CAS of 2 or less).

ii. Documentation of appreciable impact on daily life.

iii. Documentation of proptosis of 3 mm or greater above normal values for race and sex (refer to Appendix Table 3).

II. Age: 18 years of age and older.

III. Prescribed by or in consultation with an endocrinologist and/or ophthalmologist.

IV. Request is for a medication with the appropriate FDA labeling, or its use is supported by current clinical practice guidelines.

V. Refer to the plan document for the list of preferred products. If the requested agent is not listed as a preferred product, must have a documented failure, intolerance, or contraindication to a preferred product(s).

## EXCLUSION CRITERIA

- Previous treatment with Lumvoa or Tepezza
- Previous orbital irradiation
- Previous surgery for thyroid eye disease

## OTHER CRITERIA

- N/A

## QUANTITY / DAYS SUPPLY RESTRICTIONS

- Refer to Appendix Table 4

## APPROVAL LENGTH

- **Authorization:**
  - **Lumvoa:** Equivalent of 5 infusions max per lifetime.
  - **Tepezza:** Equivalent of 8 infusions max per lifetime.
- **Re-Authorization Length and Renewal Criteria:** Excluded. Continued use beyond 5 infusions for Lumvoa and 8 infusions for Tepezza has not been approved by the FDA.

## APPENDIX

**Table 1. Clinical Activity Score (CAS)**

| Item Description |
|---|
| Spontaneous retrobulbar pain |
| Pain on attempted up or lateral gaze |
| Redness of the eyelids |
| Redness of conjunctiva |
| Swelling of the eyelids |
| Inflammation of the caruncle and/or plica |
| Conjunctival edema or chemosis |
| |
| Each item is worth one point if present. Points are summed for a total score up to 7 |

**Table 2. Upper Limit of Normal for Proptosis by race and sex**

| Race | Normal Upper Limits | |
|---|---|---|
| | Female | Male |
| Black | 23 mm | 24 mm |
| White | 19 mm | 21 mm |
| Asian | 16 mm (Thai)<br>18 mm (Chinese) | 17 mm (Thai)<br>19 mm (Chinese) |

**Table 3. Gorman Score**

| Score | Description |
|---|---|
| 0 | Absent |
| 1 | Intermittent |
| 2 | Inconstant |
| 3 | Constant |

**Table 4. FDA-recommended dosage and administration, how supplied, and quantity/days supply limits**

| Medication Name Brand (generic) | Dosage and Administration | How Supplied | Quantity/Days Supply Limits |
|---|---|---|---|
| Lumvoa (veligrotug-vvze) | Dose:<br>• 10 mg/kg every three weeks for a total of 5 infusions<br><br>Administration:<br>• IV infusion over 30 to 45 minutes | 500 mg/10 mL solution in a single-dose vial | Quantity sufficient for 15-week treatment duration |
| Tepezza (teprotumumab-trbw) | Dose:<br>• First infusion: 10 mg/kg<br>• Subsequent infusions: 20mg/kg every 3 weeks for 7 additional infusions<br><br>Administration:<br>• IV infusion over 60 to 90 minutes | 500 mg lyophilized powder in a single-dose vial for reconstitution | Quantity sufficient for 24-week treatment duration |

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**DISCLAIMER:** Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgement in providing the most appropriate care for their patients.