Tzield (teplizumab-mzwv)
PAM – 082

Iowa Medicaid Program	Prior Authorization	**Effective Date**	04/01/2023
Revision Number	3	**Last Reviewed**	04/17/2026
Reviewed By	Medicaid Medical Director	**Next Review**	04/16/2027
Approved By	Medicaid Clinical Advisory Committee	**Approved Date**	07/19/2024

Overview

Medication:[1]	teplizumab-mzwv
Brand Name:	Tzield®
Pharmacologic Category:	Antidiabetic agent; CD3-directed antibody
FDA-Approved Indication(s):	Indicated to delay the onset of Stage 3 type 1 diabetes (T1D) in adults and pediatric patients aged 8 years and older with Stage 2 T1D
How Supplied:	• Single-dose vial, 2 mg/2 mL (1 mg/mL) • Supplied in carton with either 1, 10, or 14 vials
Dosage and Administration:	Administer by intravenous (IV) infusion once daily for 14 consecutive days (body surface area-based dose) • 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
Benefit Category:	Medical

Descriptive Narrative

Type 1 diabetes (T1D) is caused by immune-mediated destruction and dysfunction of insulin-producing pancreatic beta cells. Over time, overt insulin insufficiency develops, requiring exogenous insulin therapy. Historically, the diagnosis of type 1 diabetes was made at the onset of clinical signs and symptoms of hyperglycemia, often with diabetic ketoacidosis (DKA). However, with enhanced understanding of disease natural history, individuals with type 1 diabetes can be identified before the development of clinical disease.

Screening for islet autoantibodies and metabolic monitoring can detect preclinical type 1 diabetes, identify candidates for disease-modifying therapy, provide early access to diabetes-related education and support, and reduce the severity of presentation at clinical diagnosis.[2]

Type 1 diabetes develops on a background of genetic risk, but most individuals with genetic risk never develop type 1 diabetes. In contrast, virtually all individuals with ≥ 2 islet autoantibodies eventually develop clinical type 1 diabetes. Based on the recognition that these individuals almost invariably develop clinical disease, type 1 diabetes (T1D) progression is classified into discrete stages.

Staging of Type 1 Diabetes (T1D)			
Staging of T1D	Stage 1 (preclinical) T1D	Stage 2 (also preclinical disease)	Stage 3 (onset of clinical disease)
Character-istics	• Autoimmunity • Normoglycemia • Presymptomatic	• Autoimmunity • Dysglycemia • Presymptomatic	• Autoimmunity • Overt hyperglycemia • Symptomatic
Diagnostic Criteria	• Multiple islet autoantibodies • No IGT or IFG, normal A1C	• Islet autoantibodies (usually ≥ 2) • Dysglycemia ▪ IFG: FPG 100-125 mg/dL (5.6-6.9 mmol/L) or ▪ IGT: 2-h PG 140-199 mg/dL (7.8-11.0 mmol/L) or ▪ A1C 5.7-6.4% (39-47 mmol/mol) or ≥ 10% increase in A1C	• Autoantibodies may become absent • Diabetes by standard criteria

T1D, type 1 diabetes; **FPG**, fasting plasma glucose; **IFG**, impaired fasting glucose; **IGT**, impaired glucose tolerance; **2-h PG**, 2-hour plasma glucose.

Alternative additional stage 2 diagnostic criteria of 30-, 60-, or 90-min plasma glucose on oral glucose tolerance test ≥200 mg/dL (≥11.1 mmol/L) and confirmatory testing in those aged ≥18 years have been used in clinical trials. Dysglycemia can be defined by one or more criteria as outlined above.

Virtually all individuals with stage 1 type 1 diabetes will progress to stage 3 type 1 diabetes:

- approximately 25% within 5 years,
- 70% within 10 years, and
- greater than 95% within 15 years.

In individuals with preclinical (stage 1 or stage 2) type 1 diabetes, the goal of disease-modifying therapies is to prevent or delay the onset of clinical disease. In individuals with clinical (stage 3) type 1 diabetes, the goal of disease-modifying therapy is to preserve beta cell function and insulin secretion.[3]

Guidelines

The American Diabetes Association® (ADA) published *Standards of Care in Diabetes – 2026* in January 2026.[4] A grading system developed by the ADA and modeled after existing methods is used to clarify and codify the evidence that forms the basis for the recommendations in the Standards of Care. All of the recommendations in the Standards of Care are critical to comprehensive care regardless of rating. ADA recommendations are assigned ratings of **A**, **B**, or **C**, depending on the quality of the evidence in support of the recommendation. Expert opinion **E** is a separate category for recommendations in which there is no evidence from clinical trials, clinical trials may be impractical, or there is conflicting evidence. Recommendations assigned an **E** level of evidence are informed by key opinion leaders in the field of diabetes (members of the PPC and subject matter experts) and cover important elements of clinical care. All Standards of Care recommendations receive a rating for the strength of the evidence and not for the strength of the recommendation.[5]

ADA Evidence-Grading System for "Standards of Care in Diabetes"	
Level of Evidence	Description
A	Clear evidence from well-conducted, generalizable randomized controlled trials that are adequately powered, including: • Evidence from a well-conducted multicenter trial • Evidence from a meta-analysis that incorporated quality ratings in the analysis Supportive evidence from well-conducted randomized controlled trials that are adequately powered, including: • Evidence from a well-conducted trial at one or more institutions • Evidence from a meta-analysis that incorporated quality ratings in the analysis
B	Supportive evidence from well-conducted cohort studies, including: • Evidence from a well-conducted prospective cohort study or registry • Evidence from a well-conducted meta-analysis of cohort studies Supportive evidence from a well-conducted case-control study
C	Supportive evidence from poorly controlled or uncontrolled studies, including: • Evidence from randomized clinical trials with one or more major or three or more minor methodological flaws that could invalidate the results • Evidence from observational studies with high potential for bias (such as case series with comparison with historical controls) • Evidence from case series or case reports Conflicting evidence with the weight of evidence supporting the recommendation
E	Expert consensus or clinical experience

Section 2 – Classification and Diagnosis of Diabetes [6]

In the 2026 Standards of Care, Recommendation 2.8 was divided into two components to emphasize the importance of prompt evaluation for stage 3, overt type 1 diabetes in people with one or more islet autoantibodies (Recommendation 2.8a); Recommendation 2.8b maintains the original guidance that people with multiple islet autoantibodies should be referred to a specialized center for education and possibly preventative interventions.

- **Recommendation 2.6** – Screening for presymptomatic type 1 diabetes by testing autoantibodies against insulin (IA), glutamic acid decarboxylase (GAD), islet antigen 2 (IA-2), or zinc transporter 8 (ZnT8).
  - Level of evidence: **B**
- **Recommendation 2.7** – Autoantibody-based screening for presymptomatic type 1 diabetes should be offered to those with a family history of type 1 diabetes or otherwise known elevated genetic risk.
  - Level of evidence: **B**
- **Recommendation 2.8a** – Individuals with screening results positive for one or more islet autoantibodies should be evaluated for stage 3 (overt) type 1 diabetes (using A1C, urinalysis, and/or plasma glucose), which would require prompt clinical management and education.
  - Level of evidence: **B**
- **Recommendation 2.8b** – Individuals with multiple confirmed islet autoantibodies and without overt type 1 diabetes have a high risk for progression to stage 3 type 1 diabetes and should be referred to a specialized center for metabolic staging, education, and consideration of prevention trials or approved treatments (e.g., teplizumab).
  - Level of evidence: **B**

Section 3 – Prevention or Delay of Type 2 Diabetes and Associated Comorbidities [7]

In the 2026 Standards of Care, Recommendation 3.1 was broadened to include monitoring of progression from prediabetes to all types of diabetes, not only type 2 diabetes. Recommendation 3.2 was enhanced to include consideration of continuous glucose monitoring (CGM) data when monitoring for disease progression among individuals with presymptomatic type 1 diabetes.

- **Recommendation 3.1 –** In people with prediabetes, monitor for the development of diabetes at least annually; modify frequency of testing based on individual risk assessment.
  - Level of evidence: **E**
- **Recommendation 3.2** – In people with presymptomatic type 1 diabetes, monitor for disease progression using A1C approximately every 6 months and 75-g oral glucose tolerance test (i.e., fasting and 2-h plasma glucose) annually; modify frequency of monitoring and consider augmenting with other glycemic assessment tools such as continuous glucose monitoring metrics based on individual risk assessment incorporating age, number and type of autoantibodies, and glycemic metrics.
  - Level of evidence: **E**
- **Recommendation 3.17** – **Teplizumab-mzwv infusion** to delay the onset of symptomatic type 1 diabetes (stage 3) should be discussed with selected individuals aged $\geq$ 8 years with stage 2 type 1 diabetes. Treatment should be in a setting with appropriately trained personnel.
  - Level of evidence: **B**

Criteria

Prior authorization is required.

Tzield® is considered medically necessary when **ALL** of the following are met:

1. Diagnosis of type 1 diabetes (T1D), stage 2, as confirmed by **ALL** of the following (a, b, and c):
    a. Presence of **TWO** or more of the following pancreatic islet autoantibodies:
        i. Glutamic acid decarboxylase 65 (GAD) autoantibodies; and/or
        ii. Insulin autoantibody (IAA); and/or
        iii. Insulinoma-associated antigen 2 autoantibody (IA-2A); and/or
        iv. Zinc transporter 8 autoantibody (ZnT8A); and/or
        v. Islet cell autoantibody (ICA); **AND**
    b. Abnormal glucose tolerance during an oral glucose-tolerance test (OGTT) within the past 60 days (or alternative glycemic test if an oral glucose-tolerance test is not available) (i, ii, or iii):
        i. Fasting plasma glucose level of 110 to 125 mg/dL (6.1 to 6.9 mmol/L); or
        ii. 2-hour plasma glucose level of 140 to 199 mg/dL (7.8 to 11.1 mmol/L); or
        iii. Postprandial plasma glucose level at 30, 60, or 90 minutes of greater than 200 mg/dL; **AND**
    c. Member does not have symptoms of diabetes (e.g., polyuria, polydipsia, polyphagia); **AND**
2. Member is 8 years of age or older; **AND**
3. Prescribed by, or in consultation with, an endocrinologist; **AND**
4. Member does **NOT** have a diagnosis of Stage 3 T1D or type 2 diabetes; **AND**
5. Member has not received a previous 14-day course of Tzield®; **AND**
6. Request meets one of the following (a or b):
    a. Regimen prescribed does not exceed a 14-day course at the following doses:
        i. Day 1: 65 mcg/m^2
        ii. Day 2: 125 mcg/m^2
        iii. Day 3: 250 mcg/m^2
        iv. Day 4: 500 mcg/m^2
        v. Days 5 through 14: 1,030 mcg/m^2 per day; or
    b. Regimen is supported by clinical practice guidelines. Supporting clinical documentation must be provided with any request for which regimen prescribed does not align with FDA-approved labeling.

Tzield® is **NOT** considered medically necessary for continuation of therapy, as it is indicated to be administered as a one-time treatment course only.

Approval Duration and Quantity Limits

Approval Duration	Maximum Dose (based on body surface area of member)
30 days (to allow for 14 total days of treatment)	Not to exceed 14 days of therapy; dose per day as follows: • 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 per day

Coding and Product Information

The following list(s) of codes and product information are provided for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment, nor does the exclusion of a code imply that its association to the HCPCS code is inappropriate.

HCPCS	Description
~~C9149~~	~~Injection, teplizumab-mzwv, 5 mcg~~ *(effective 4-1-23 to 6-30-23)*
J9381	Injection, teplizumab-mzwv, 5 mcg *(effective 7-1-2023)*

ICD-10	Description
E10.1 – E10.9	Type 1 diabetes mellitus

NDC (2 mg/2 mL single-dose vial) (# of SDVs per carton)	Labeler	Dosage	Pkg Size	Pkg Qty	Units/ Pkg
73650-0316-01 (1 SDV)	Provention Bio, Inc. (73650)	5 mcg	1	EA	400
73650-0316-10 (10 SDV)	Provention Bio, Inc. (73650)	5 mcg	1	EA	4,000
73650-0316-14 (14 SDV)	Provention Bio, Inc. (73650)	5 mcg	1	EA	5,600

Compliance

1. Should conflict exist between the policy and applicable statute, the applicable statute shall supersede.
2. Federal and State law, as well as contract language, including definitions and specific contract provisions or exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage.
3. Medical technology is constantly evolving, and Iowa Medicaid reserves the right to review and update medical policy on an annual or as-needed basis.

Medical necessity guidelines have been developed for determining coverage for member benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. Medical necessity guidelines are developed for selected physician-administered medications found to be safe and proven to be effective in a limited, defined population or clinical circumstances. They include concise clinical coverage criteria based on current

literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Criteria are revised and updated annually, or more frequently if new evidence becomes available that suggests needed revisions.

References

[1] Tzield® prescribing information (04/2025). Provention Bio, Inc.: Red Bank, NJ. Available online at: www.tzieldhcp.com. Accessed January 30, 2026.

[2] Greenbaum CJ, Lord S, Speake C. Type 1 diabetes mellitus: Disease prediction and screening. Rubinow K, ed. UpToDate. Waltham, MA: UpToDate Inc. www.uptodate.com. Accessed February 12, 2026.

[3] Greenbaum CJ, Lord S, Speake C. Type 1 diabetes mellitus: Prevention and disease-modifying therapy. Rubinow K, ed. UpToDate. Waltham, MA: UpToDate Inc. www.uptodate.com. Accessed February 12, 2026.

[4] American Diabetes Association Professional Practice Committee for Diabetes - Standards of Care in Diabetes-2026. Diabetes Care. 2026 Jan 1;49 (Supplement_1). Available online at diabetesjournals.org/care/issue/49/Supplement_1.

[5] American Diabetes Association Professional Practice Committee. Introduction and Methodology: Standards of Care in Diabetes-2026. Diabetes Care. 2026 Jan 1;49(Supplement_1):S1-S5. PMID 41358883.

[6] American Diabetes Association Professional Practice Committee. 2. Diagnosis and Classification of Diabetes: Standards of Care in Diabetes-2026. Diabetes Care. 2026 Jan 1;49(Supplement_1):S50-S60. PMID: 41358893.

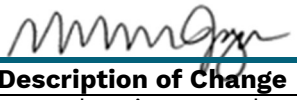
[7] American Diabetes Association Professional Practice Committee. 3. Prevention or Delay of Diabetes and Associated Comorbidities: Standards of Care in Diabetes-2026. Diabetes Care. 2026 Jan 1;49(Supplement_1):S50-S60. PMID: 41358891.

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

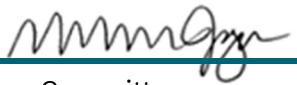
Criteria Change History

Change Date	Changed By	Description of Change	Version
[mm/dd/yyyy]	CAC		
Signature			

Change Date	Changed By	Description of Change	Version
[mm/dd/yyyy]	CAC		
Signature			

Change Date	Changed By	Description of Change	Version
04/17/2026	CAC	Annual review. Updated references. Descriptive Narrative: added a table outlining the staging of type 1 diabetes. Guidelines: updated with guidance from "American Diabetes Association Professional Practice Committee for Diabetes - Standards of Care in Diabetes-2026" (published Jan 1, 2026).	3
Signature William (Bill) Jagiello, DO			

Change Date	Changed By	Description of Change	Version
04/18/2025	CAC	Annual review. No changes.	2
Signature William (Bill) Jagiello, DO			

Change Date	Changed By	Description of Change	Version
07/19/2024	CAC	Criteria implementation.	1
Signature William (Bill) Jagiello, DO			

CAC = Medicaid Clinical Advisory Committee