



Actemra, Tofidence, Tyenne

HMSA Medicare Advantage - Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-237-5512.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____ *kg*
Patient Height: _____ *ft* _____ *inches*

Indicate where the drug is being dispensed:

- Office Outpatient Hospital Ambulatory Surgical Inpatient Hospital
- Off Campus Outpatient Hospital Urgent Care Emergency Room Birthing Center
- Military Facility Skilled Nursing Facility Nursing Facility Hospice
- Inpatient Psychiatric Psychiatric Residential Treatment End Stage Renal Facility
- Psychiatric Facility Pharmacy Other

Indicate where the drug is being administered:

- Ambulatory surgical Home Inpatient Hospital
- Office Outpatient Hospital Pharmacy

What is the ICD-10 code? _____

What product is being requested? Actemra Tofidence Tyenne

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message Actemra, Tofidence, Tyenne HMSAMED C26640-A – 04/2026.

CVS Caremark Specialty Programs • 2969 Mapunapuna Place • Honolulu, HI 96819
Phone: 1-808-254-4414 • Fax: 1-866-237-5512 • www.caremark.com

Criteria Questions:

1. Is the patient currently receiving treatment with the requested drug?

- Yes, *Continue to #2*
- No, *Continue to #4*

2. What is the patient's diagnosis?

- Rheumatoid arthritis, *Continue to #3*
- Juvenile idiopathic arthritis, *Continue to #3*
- Giant cell arteritis, *Continue to #3*
- Unicentric Castleman disease, *Continue to #3*
- Multicentric Castleman disease, *Continue to #3*
- Immunotherapy-related inflammatory arthritis, *Continue to #3*
- Cytokine release syndrome, *Continue to #7*
- Acute graft versus host disease, *Continue to #4*
- Thyroid eye disease, *Continue to #3*
- Polymyalgia rheumatica, *Continue to #3*
- Other, *No Further Questions*

3. Is the patient receiving benefit from therapy?

- Yes, *No Further Questions*
- No, *No Further Questions*

4. What is the patient's diagnosis?

- Rheumatoid arthritis, *No Further Questions*
- Giant cell arteritis, *No Further Questions*
- Juvenile idiopathic arthritis, *Continue to #6*
- Unicentric Castleman disease, *No Further Questions*
- Multicentric Castleman disease, *No Further Questions*
- Immunotherapy-related inflammatory arthritis, *No Further Questions*
- Cytokine release syndrome, *Continue to #7*
- Acute graft versus host disease, *No Further Questions*
- Thyroid eye disease, *Continue to #9*
- Polymyalgia rheumatica, *No Further Questions*
- Other, *No Further Questions*

5. Does the patient have polyarticular or systemic juvenile idiopathic arthritis?

- Yes, *No Further Questions*
- No, *No Further Questions*

6. Has the patient been diagnosed with chimeric antigen receptor (CAR) T cell-induced cytokine release syndrome?

- Yes, *No Further Questions*
- No, *Continue to #8*

7. Does the patient have refractory cytokine release syndrome (CRS) related to blinatumomab therapy?

- Yes, *No Further Questions*
- No, *No Further Questions*

8. Does the patient have active Graves' orbitopathy?

- Yes, *No Further Questions*
- No, *No Further Questions*

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I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X _____

Prescriber or Authorized Signature

Date (mm/dd/yy)

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