Tepezza

HMSAMCD- 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? _____

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. Tepezza HMSAMCD C28157-A– 1/2025.

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. What is the diagnosis?

❒ Thyroid eye disease (TED), *Continue to #2*

❒ Other, *Continue to Criteria Exception Policy*

2. Will the requested medication be prescribed by or in consultation with an ophthalmologist?

❒ Yes, *Continue to #3*

❒ No, *Continue to #3*

3. Has the patient previously received treatment with the requested medication?

❒ Yes, *Continue to #4*

❒ No, *Continue to #4*

4. Does the patient have moderate-to-severe disease? ***ACTION REQUIRED****: If Yes, please attach supporting chart note(s) or medical record indicating moderate-to-severe disease assessment*

❒ Yes, *Continue to #5*

❒ No, *Continue to #5*

5. Does the patient have active or inactive disease?

❒ Yes, *Continue to #6*

❒ No, *Continue to #6*

6. Which of the following applies to the patient?

❒ Lid retraction greater than or equal to 2 mm, *Continue to #7*

❒ Moderate or severe soft-tissue involvement, *Continue to #7*

❒ Exophthalmos greater than or equal to 3 mm above normal for race and gender, *Continue to #7*

❒ Inconstant or constant diplopia, *Continue to #7*

❒ None of the above, *Continue to #7*

7. Is the patient 18 years of age or older?

❒ Yes, *Continue to #8*

❒ No, *Continue to #8*

8. Does the patient exceed a one-time treatment course consisting of 8 infusions given once every 3 weeks (e.g., 10 mg/kg on first infusion, followed by 20 mg/kg every 3 weeks for 7 additional infusions)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

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)**

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. Tepezza HMSAMCD C28157-A– 1/2025.

CVS Caremark Specialty Programs ● 2969 Mapunapuna Place ● Honolulu, HI 96819

Phone: 1-808-254-4414 ● Fax: 1-866-237-5512 ● www.caremark.com