



Fax Transmittal

Fax: {Auth.OfficeContactFaxNumber}
To: {Auth.ProviderBilling.Name.Legal}

From: CVS

Fax: (855) 330-1720

Re: Prior Authorization for {Auth.Member.MemberNameFirst}
{Auth.Member.MemberNameLast}

<p>Electronically (4-5 minutes process time)</p>	<p>Phone (10-15 minutes process time)</p>	<p>Fax (24-72 hours process time)</p>
<p>CVS/Caremark now accepts PA requests on-line 24/7. No fax machines, no phone hold times, faster approval.</p> <p>Most requests will not require a fax or phone call.</p> <p>To request a Prior Authorization online, navigate to https://provider.carefirst.com/providers/home.page and click on the orange tab in the upper right hand corner; or for more details about how to submit and review your prior authorization requests online, view the training video available at www.carefirst.com/learninglibrary > Pharmacy.</p>	<p>Calling us with your PA request during our business hours is another option</p> <p>The process over the phone can take between 10 and 15 minutes.</p> <p>OR online</p>	<p>You may also continue to fax us your PA request</p> <p>Faxes received are processed within 24 to 72 hours.</p> <p>OR online</p>

The information contained in this message may be privileged and confidential and protected from disclosure. If the reader of this message is not the intended recipient, or an employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by replying to the message and deleting it from your computer. Thank you, CVS/Caremark.

Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:**
{Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}



Tepezza

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 1-855-330-1720.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518**. 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 Name: {Auth.Member.MemberNameFirst}
{Auth.Member.MemberNameLast}
Patient's ID: {Auth.Member.MemberID}

Date: {System.DateTime.Today}

Physician's Name: {Auth.ProviderBilling.Name.Legal}
Specialty: _____
Physician Office Telephone: {Auth.OfficeContactPhoneNumber}

Patient's Date of Birth:
{Auth.Member.MemberBirthDate}
NPI#: {Auth.ProviderBilling.NPI}
Physician Office Fax:
{Auth.OfficeContactFaxNumber}

Referring Provider Info: Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: Same as Referring Provider Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

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

Required Demographic Information:

Patient Weight: _____ *kg*

Patient Height: _____ *cm*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

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CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062
Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com

Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:**
{Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}

Site of Service Questions (SOS):

- A. Indicate the site of service requested:
- | | |
|---|--|
| <input type="checkbox"/> On Campus Outpatient Hospital | <input type="checkbox"/> Off Campus Outpatient Hospital |
| <input type="checkbox"/> Home infusion, <i>skip to Criteria Questions</i> | <input type="checkbox"/> Physician office, <i>skip to Criteria Questions</i> |
| <input type="checkbox"/> Ambulatory surgical, <i>skip to Criteria Questions</i> | <input type="checkbox"/> Pharmacy, <i>skip to Criteria Questions</i> |
- B. Is this request to continue previously established treatment with the requested medication?
- Yes – This is a continuation of an existing treatment
 No – This is a new therapy request (patient has not received requested medication in the last 6 months).
Skip to Clinical Criteria Questions
- C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** Yes, *skip to Clinical Criteria Questions* No
- D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member’s ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation.
 Yes, *skip to Clinical Criteria Questions* No
- E. Does the patient have severe venous access issues that require the use of a special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
 Yes, *skip to Clinical Criteria Questions* No
- F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation. Yes No

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Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:**
{Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}

Criteria Questions:

What is the ICD-10 code? _____

1. What is the diagnosis?
 Thyroid eye disease (TED) (*If checked, go to 2*)
 Other, please specify. _____ (*If checked, go to 2*)
2. Is the requested medication being 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:** Please attach disease severity assessment or supporting chart note(s).
 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 (*If checked, go to 7*)
 Moderate or severe soft-tissue involvement (*If checked, go to 7*)
 Exophthalmos greater than or equal to 3 mm above normal for race and gender (*If checked, go to 7*)
 Inconstant or constant diplopia (*If checked, go to 7*)
 None of the above (*If checked, go 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., 10mg/kg on first infusion, followed by 20mg/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)

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