



## 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.

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**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_

**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**

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 SOC SGM 8/2021.

**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](http://www.caremark.com)**

**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

**Criteria Questions:**

1. What is the diagnosis?  
 Thyroid eye disease  
 Other \_\_\_\_\_
2. What is the ICD-10 code? \_\_\_\_\_
3. Has the patient previously received treatment with the requested medication?  Yes  No
4. Does the patient have active disease?  Yes  No
5. What is the patient’s clinical activity score (CAS)? ***ACTION REQUIRED: Attach disease activity assessment or supporting chart note(s).*** \_\_\_\_\_
6. Does the patient have moderate-to-severe disease? ***ACTION REQUIRED: Attach disease severity assessment or supporting chart note(s).***  Yes  No
7. Is the requested medication being prescribed by or in consultation with an ophthalmologist?  Yes  No

***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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