Tepezza

CareFirst 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'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*

What is the ICD-10 code? _____

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

Criteria Questions:

1. What is the diagnosis?

❒ Thyroid Eye Disease (TED), *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

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: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

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