Bylvay

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 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** 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:** ____________________
Request Initiated For: ________________________

1. What is the diagnosis?
   ❑ Pruritis in progressive familial intrahepatic cholestasis (PFIC)
   ❑ Other ____
2. What is the ICD-10 code? ________________
3. Does the patient have progressive familial intrahepatic cholestasis (PFIC) type 2?
   ❑ Yes ❑ No *If No, skip to #5*
4. Does the patient have progressive familial intrahepatic cholestasis (PFIC) type 2 with variants in the ABCB11 gene that predict non-functional or complete absence of the bile salt export pump protein (BSEP-3)?
   ❑ Yes ❑ No ***By answering No, you are attesting that the patient's genetic testing report does not indicate the presence of a variant that may be suggestive of nonfunctional BSEP-3 protein.***
5. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #8*
6. Is the requested drug being prescribed by or in consultation with a hepatologist? ❑ Yes ❑ No
7. Is the patient experiencing benefit from therapy (e.g., improvement in pruritis)? ***ACTION REQUIRED: If Yes, attach chart notes or medical records documenting a benefit from therapy (e.g., improvement in pruritis).***
   ❑ Yes ❑ No *No further questions*
8. What progressive familial intrahepatic cholestasis (PFIC) type does the patient have?
   ❑ PFIC type 1
   ❑ PFIC type 2
   ❑ PFIC type 3
   ❑ Other ____
9. Does the patient have a confirmed molecular diagnosis of progressive familial intrahepatic cholestasis (PFIC) type 1, 2, or 3? ***ACTION REQUIRED: If Yes, attach genetic testing results confirming a diagnosis of PFIC type 1, 2, or 3.*** ❑ Yes ❑ No

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

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10. Does the patient have any other concomitant liver disease (e.g., biliary atresia, benign recurrent intrahepatic cholestasis [BRIC], liver cancer, alternate non-PFIC related etiology of cholestasis)? ❑ Yes ❑ No
11. Has the patient received a liver transplant? ❑ Yes ❑ No
12. Is the requested drug being prescribed by or in consultation with a hepatologist? ❑ 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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CVS Caremark Prior Authorization ● 1300 E. Campbell Road ● Richardson, TX 75081
Phone: 1-866-814-5506 ● Fax: 1-866-249-6155 ● www.caremark.com