

Cholbam
Prior Authorization Request

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

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?
 - Bile acid synthesis disorder due to single enzyme defect (SED)
 - Peroxisomal disorder (PD), including Zellweger spectrum disorders
 - Other _____
2. What is the ICD-10 code? _____
3. *If being prescribed for peroxisomal disorder (PD), including Zellweger spectrum disorders*, is Cholbam being requested for use as adjunctive treatment of a peroxisomal disorder? Yes No Not applicable
4. Was the diagnosis confirmed by mass spectrometry or other biochemical testing or genetic testing? Yes No
5. Is this request for continuation of therapy with Cholbam? Yes No *If No, no further questions.*
6. Has the patient achieved and maintained improvement in liver function? 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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