

Member Name: {{MEMFIRST}} {{MEMLAST}} DOB: {{MEMBERDOB}} PA Number: {{PANUMBER}}



[[PANUMCODE]]

Cholbam

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: {{MEMFIRST}} {{MEMLAST}} **Date:** {{TODAY}}
Patient's ID {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

- What is the diagnosis?
 Bile acid synthesis disorder due to single enzyme defect (SED)
 Peroxisomal disorder (PD), including Zellweger spectrum disorders
 Other _____
- What is the ICD-10 code? _____
- If patient's diagnosis is peroxisomal disorder, is Cholbam being requested for use as adjunctive treatment?
 Yes No
- Is this request for continuation of therapy with Cholbam, which the patient is receiving via a pharmacy or medical benefit? Yes No *If No, skip to diagnosis section.*
- Has the patient achieved and maintained improvement in liver function from baseline (i.e. reduced transaminases, reduced bilirubin, no evidence of cholestasis on liver biopsy)? **ACTION REQUIRED: If 'Yes', attach supporting chart note(s) or lab results and no further questions.** Yes No

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Bile Acid Synthesis Disorder

- Was the diagnosis confirmed by mass spectrometry, enzyme assay, biochemical testing, or genetic testing?
ACTION REQUIRED: If 'Yes', attach supporting chart note(s) or test results. Yes No
- Does the patient have liver dysfunction (i.e., elevated transaminases, bilirubin, presence of cholestasis) at baseline? **ACTION REQUIRED: If 'Yes', attach supporting chart note(s) or lab results.** Yes No

Section B: Peroxisomal Disorder

- Was the diagnosis confirmed by mass spectrometry or other biochemical testing or genetic testing?
ACTION REQUIRED: If 'Yes', attach supporting chart note(s) or test results. Yes No
- Does the patient have lab results documenting baseline liver function (i.e., transaminases, bilirubin, presence of cholestasis)? **ACTION REQUIRED: If 'Yes', attach supporting chart note(s) or lab results.** 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 exhibit manifestations of liver disease? 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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