Evkeeza

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*

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

Site of Service Questions:

A. Where will this drug be administered?

- ❑ Ambulatory surgical, *skip to Criteria Questions*
- ❑ Home infusion, *skip to Criteria Questions*
- ❑ Off-campus Outpatient Hospital
- ❑ On-campus Outpatient Hospital
- ❑ Physician office, *skip to Criterial Questions*
- ❑ Pharmacy, *skip to Criteria Questions*

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 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) 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 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 Criteria Questions* ❑ No

E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes, *skip to 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. Does the patient have a documented diagnosis of homozygous familial hypercholesterolemia? ❑ Yes ❑ No
2. What is the ICD-10 code? _____
3. Which of the following confirmed the patient's diagnosis of homozygous familial hypercholesterolemia? ***Action Required: Attach genetic testing or supporting medical records.***
   ❑ Functional mutation or mutations in both low-density lipoprotein (LDL) receptor alleles s*kip to #6*
   ❑ Presence of homozygous or compound heterozygous mutations in apolipoprotein B (APOB) or PCSK9 s*kip to #6*
   ❑ Member is double heterozygous (i.e., mutations on different genes [e.g., LDLR/PCSK9]) or homozygous for LDL receptor adaptor protein 1 (LDLRAP1) mutations s*kip to #6*
   ❑ None of the above
   ❑ Other
4. What was the patient's untreated (i.e., before treatment with any lipid lowering therapy) total cholesterol level in mg/dL?
   Action Required: Attach supporting medical records. _____mg/dL ❑ Unknown
5. Which of the following applies to the patient? ***Action Required: Attach supporting medical records.***
   ❑ Presence of cutaneous or tendinous xanthomas before the age of 10 years
   ❑ An untreated total cholesterol level of more than 250 mg/dL in both parents
   ❑ Neither- The patient does not meet any of the criteria listed above
6. Prior to initiation of treatment with the requested medication, what was the patient's LDL-C level?
   Action Required: For initial request, attach medical records indicating the current LDL-C level. For continuation of therapy request, attach medical records of LDL-C level prior to initiation of treatment with the requested medication. The level must be dated within the six months preceding the authorization request of initial treatment with the requested medication.
   LDL-C level _____mg/dL
7. Prior to initiation of treatment with the requested drug, is/was the patient receiving stable treatment with at least 3 lipid-lowering therapies (for example, statins, ezetimibe, PCSK9 inhibitors) at the maximum tolerated dose*?* ***Action Required: Attach medical records confirming lipid lowering therapy.*** ❑ Yes ❑ No
8. Will the patient continue to receive concomitant lipid-lowering therapy? ❑ Yes ❑ No
9. Is the patient currently receiving the requested drug? ❑ Yes ❑ No *If No, no further questions*
10. What is the current LDL-C level? ***Action Required: Attach medical records indicating the current treated LDL-C level. The LDL-C level must be dated within the six months preceding the authorization request*** LDL-C level _____mg/dL
11. Has the patient achieved or maintained an LDL-C reduction as evidenced by either of the following?
    ❑ LDL-C is now at goal
    ❑ At least 40% reduction of LDL-C from baseline
    ❑ None of the above
12. Is the patient currently receiving concomitant lipid-lowering therapy? ***Action Required: Attach medical records confirming lipid lowering therapy.*** ❑ 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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