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*

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

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

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:

What is the ICD-10 code? _____

1. Does the patient have a documented diagnosis of homozygous familial hypercholesterolemia?

❒ Yes, *Continue to #2*
❒ No, *Continue to #2*

2. Does the patient possess variant in two low-density lipoprotein receptor (LDLR) alleles? ***ACTION REQUIRED***: Attach genetic testing or supporting medical records.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 8*

❒ No, *Continue to 3*

❒ Unknown, *Continue to 5*

3. Does the patient have presence of homozygous or compound heterozygous variants in apolipoprotein B (APOB) or proprotein convertase subtilisin-kexin type 9 (PCSK9)? ***ACTION REQUIRED***: Attach genetic testing or supporting medical records.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 8*

❒ No, *Continue to 4*

❒ Unknown, *Continue to 5*

4. Does the patient have compound heterozygosity or homozygosity for variants in the gene encoding low-density lipoprotein receptor adaptor protein 1 (LDLRAP1)? ***ACTION REQUIRED***: Attach genetic testing or supporting medical records.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 8*

❒ No, *Continue to 5*

❒ Unknown, *Continue to 5*

5. What was the patient's untreated (i.e., before treatment with any lipid-lowering therapy) LDL-C level in mg/dL? (Fill in the blank) ***ACTION REQUIRED***: Attach supporting medical records.

❒ Greater than 500 mg/dL _____ mg/dL, *Continue to 7*

❒ Less than or equal to 500 mg/dL _____mg/dL, *Continue to 6*

❒ Unknown, *Continue to 6*

6. What is the patient's treated (i.e., after initiation of lipid-lowering therapy but before treatment with the requested medication) LDL-C level in mg/dL? ***ACTION REQUIRED***: Attach supporting medical records.

❒_____ mg/dL, *Continue to 7*

❒ Unknown, *Continue to 7*

7. 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, *Continue to 8*

❒ An untreated LDL-C level of greater than or equal to 190 mg/dL in both parents, *Continue to 8*

❒ Neither - The patient does not meet any of the criteria listed above, *Continue to 8*

❒ Unknown, *Continue to 8*

8. Does the patient have clinical atherosclerotic cardiovascular disease (ASCVD) (e.g., myocardial infarction, acute coronary syndromes, coronary or other arterial revascularization procedure [e.g., percutaneous coronary intervention [PCI], coronary artery bypass graft [CABG] surgery])?
❒ Yes, *Continue to 10*
❒ No, *Continue to 9*

9. Prior to initiation of treatment with the requested medication, what is/was the patient's treated LDL-C level? Indicate LDL-C level in mg/dL. ***ACTION REQUIRED***: Attach medical records indicating LDL-C levels dated within the six months preceding the request.

_____mg/dL, *Continue to 11*

10. Prior to initiation of treatment with the requested medication, what is/was the patient's treated LDL-C level in mg/dL? ***ACTION REQUIRED***: Attach medical records indicating LDL-C levels dated within the six months preceding the request.

_____ mg/dL, *Continue to 11*

11. What is the patient's age in years?

❒ Less than 5 years of age, *No further questions*

❒ 5 years of age to less than 7 years of age, *Continue to 17*

❒ 7 years of age to less than 10 years of age, *Continue to 14*

❒ 10 years of age or older, *Continue to 12*

12. Prior to initiation of treatment with the requested medication, is/was the patient receiving stable treatment with at least 3 lipid-lowering therapies (for example, statins, ezetimibe, proprotein convertase subtilisin/kexin type 9 [PCSK9] directed therapy) at the maximally tolerated dose? ***ACTION REQUIRED***: Attach chart notes, medical record documentation, or claims history confirming the lipid-lowering therapy.
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Will the patient continue to receive concomitant therapy with 3 lipid-lowering agents (e.g., statins, ezetimibe, proprotein convertase subtilisin/kexin type 9 (PCSK9) directed therapy) at the maximally tolerated dose? ***ACTION REQUIRED***: Attach chart notes, medical record documentation, or claims history confirming the lipid-lowering therapy.

❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

14. Prior to initiation of treatment with the requested medication, is/was the patient receiving stable treatment with at least one maximally tolerated lipid-lowering therapy (e.g., statins, LDL apheresis)? ***ACTION REQUIRED***: Attach chart notes, medical record documentation, or claims history confirming the lipid-lowering therapy.
❒ Yes, *Continue to 15*
❒ No, *Continue to 16*

15. Will the patient continue to receive concomitant therapy with one maximally tolerated lipid-lowering therapy (e.g., statins, LDL apheresis)? ***ACTION REQUIRED***: Attach chart notes, medical record documentation, or claims history confirming the lipid-lowering therapy.
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

16. Does the patient have an intolerance or contraindication to other lipid-lowering therapies? ***ACTION REQUIRED***: Attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 18*
❒ No, *No Further Questions*

18. What is the current LDL-C level in mg/dL? ***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.

❒ _____ mg/dL, *Continue to 19*

❒ Unknown, *Continue to 19*

19. Has the patient achieved or maintained an LDL-C reduction as evidenced by either of the following?

❒ LDL-C is now at goal, *Continue to 20*

❒ At least 30% reduction of LDL-C from baseline, *Continue to 20*

❒ None of the above, *Continue to 20*

20. What is the patient's age in years?

❒ Less than 5 years of age, *No further questions*

❒ 5 years of age to less than 7 years of age, *No further questions*

❒ 7 years of age to less than 10 years of age, *Continue to 21*

❒ 10 years of age or older, *Continue to 23*

21. Is the patient currently receiving concomitant lipid-lowering therapy at the maximally tolerated dose? ***ACTION REQUIRED***: Attach chart notes, medical record documentation, or claims history confirming the lipid-lowering therapy.
❒ Yes, *No Further Questions*
❒ No, *Continue to 22*

22. Does the patient have an intolerance or contraindication to other lipid-lowering therapies? ***ACTION REQUIRED***: Attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

23. Is the patient currently receiving concomitant lipid-lowering therapy at the maximally tolerated dose? ***ACTION REQUIRED***: Attach chart notes, medical record documentation, or claims history confirming the lipid-lowering therapy.
❒ 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