Leqvio

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.

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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:** ___________________

<u>Referring</u> Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** ______________________

<u>Rendering</u> 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.

<u>Required Demographic Information:</u>

Patient Weight: __________________________*kg*

*Patient Height:*___________________________*cm*

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Leqvio SGM 5116-A – 09/2022.

Clinical Criteria Questions:

1. What is the diagnosis?
   - ❑ Clinical atherosclerotic cardiovascular disease (ASCVD)
   - ❑ Heterozygous familial hypercholesterolemia (HeFH)
   - ❑ Other ____

2. What is the ICD-10 code? _________________

3. What is the current LDL-C level in mg/dL? ____________ mg/dL
   ACTION REQUIRED: Attach chart notes indicating the current treated LDL-C level. The LDL-C level must be dated within the six months preceding the authorization request.

4. Is this request for continuation of therapy with Leqvio? *If Yes skip to #10* ❑ Yes ❑ No

5. Is the patient receiving a high-intensity statin dose daily, such as rosuvastatin (Crestor) 20 mg daily or atorvastatin (Lipitor) 40 mg daily? *If Yes skip to #7* ❑ Yes ❑ No

6. Is the patient receiving a moderate-intensity statin dose daily, such as atorvastatin (Lipitor) 20 mg or equivalent? ❑ Yes ❑ No *If No, skip to #13*

7. Has the patient received this dose for at least 3 months? *If Yes, skip to #12* ❑ Yes ❑ No

8. *If the patient is receiving a high-intensity statin dose daily, such as rosuvastatin (Crestor) 20 mg daily or atorvastatin (Lipitor) 40 mg daily AND the patient received this dose for at least 3 months*, was the patient unable to tolerate a high-intensity statin due to adverse effects? ❑ Yes ❑ No *If No, skip to #13*

9. Will the patient continue to receive concomitant statin therapy? *If Yes, skip to #13* ❑ Yes ❑ No

10. Has the patient achieved or maintained an LDL-C reduction (e.g., LDL-C is now at goal, robust lowering of LDL-C) as the result of Leqvio therapy? ❑ Yes ❑ No

11. Is the patient currently receiving concomitant statin therapy? ❑ Yes ❑ No *If No, skip to #13*

12. Will the patient continue to receive concomitant statin therapy? *If Yes, no further questions* ❑ Yes ❑ No

13. Did the patient score a 7 or higher on the Statin-Associated Muscle Symptom Clinical Index (SAMS-CI)? ***ACTION REQUIRED: Attach chart notes confirming the SAMS-CI score.*** ❑ Yes ❑ No
    If continuation of therapy and Yes, no further questions; If Initial of therapy and Yes, skip to diagnosis section

14. Did the patient experience a statin-associated increase in creatine kinase (CK) level of greater than or equal to 10 times the upper limit of normal (ULN) during previous treatment with a statin? ***ACTION REQUIRED: Attach chart notes confirming the CK levels.*** ❑ Yes ❑ No
    If continuation of therapy and Yes, no further questions; If Initial of therapy and Yes, skip to diagnosis section

15. Does the patient have any of the following contraindications to statins? ***ACTION REQUIRED: Attach chart notes confirming the contraindication.***
    - ❑ Active liver disease, including unexplained persistent elevations in hepatic transaminase levels (e.g., ALT greater than or equal to 3 times upper limit of normal)
    - ❑ Currently pregnant
    - ❑ Planning pregnancy
    - ❑ Breastfeeding
    - ❑ None of the above

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

Section A: Clinical Atherosclerotic Cardiovascular Disease (ASCVD)

16. Which of the manifestations of clinical atherosclerotic cardiovascular disease (ASCVD) has the patient experienced? ***ACTION REQUIRED: Attach chart notes confirming clinical atherosclerotic cardiovascular disease.***
    - ❑ Acute coronary syndrome(s)
    - ❑ Myocardial infarction

- ❑ Stable or unstable angina
- ❑ Coronary or other arterial revascularization procedure (e.g., percutaneous coronary intervention [PCI], coronary artery bypass graft [CABG] surgery)
- ❑ Stroke of presumed atherosclerotic origin
- ❑ Transient ischemic attack (TIA)
- ❑ Non-cardiac peripheral arterial disease (PAD) of presumed atherosclerotic origin (e.g., carotid artery stenosis, lower extremity PAD)
- ❑ Obstructive coronary artery disease (defined as fifty percent or greater stenosis on cardiac computed tomography angiogram or catheterization)
- ❑ Coronary Artery Calcium (CAC) score of greater than or equal to 1000
- ❑ Other ____

Section B: Heterozygous Familial Hypercholesterolemia (HeFH)

17. Does the patient possess an LDL-receptor mutation, familial defective apo B-100 or a PCSK9 mutation?
    ACTION REQUIRED: Attach genetic testing records confirming diagnosis of HeFH.
    If Yes, no further questions ❑ Yes ❑ No

18. What is the patient's untreated (before any lipid-lowering therapy) LDL-C level in mg/dL?
    ACTION REQUIRED: Attach chart notes indicating the untreated LDL-C level. ____________ mg/dL

19. Does the patient meet at least one of the following criteria? ***ACTION REQUIRED: Attach chart notes or medical records confirming the clinical diagnosis of HeFH.***
    - ❑ Presence of tendon xanthoma(s) in the patient or first/second-degree
    - ❑ Family history of myocardial infarction (MI) at less than 60 years of age in a first degree relative or less than 50 years of age in a second degree relative
    - ❑ Family history of total cholesterol (TC) greater than 290 mg/dL in a first/second degree relative
    - ❑ None of the above – the patient does not meet any of the criteria listed above

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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