Juxtapid

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.

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:** _____
Request Initiated For: _____

1. What is the diagnosis?
   ❑ Homozygous familial hypercholesterolemia (HoFH)
   ❑ Other _____
2. What is the ICD-10 code? _____
3. The preferred products for your patient's health plan is Praluent. Can the patient's treatment be switched to the preferred product? ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   ❑ Yes - Praluent ❑ No - continue request for Juxtapid
4. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #6*
5. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. ❑ Yes ❑ No *If No, skip to #8*
6. Does the patient have a documented inadequate response to treatment with the preferred product, Praluent? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) and skip to #8.*** ❑ Yes ❑ No
7. Does the patient have a documented intolerable adverse event to the preferred product, Praluent? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No
8. Does the patient possess variant in two low-density lipoprotein receptor (LDLR) alleles? ***ACTION REQUIRED: Attach genetic testing or supporting medical records.***
   If Yes, skip to #14 ❑ Yes ❑ No ❑ Unknown *If Unknown skip to #11*
9. 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.*** *If Yes, skip to #14* ❑ Yes ❑ No ❑ Unknown *If Unknown skip to #11*
10. 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.*** *If Yes, skip to #14*

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

11. What is the patient's untreated (i.e., before treatment with any lipid lowering therapy) LDL-C level in mg/dL? ***ACTION REQUIRED: Attach supporting medical records.*** **_____ *mg/dL*** ❑ Unknown
If greater than 500mg/dL, skip to #13

12. 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* ❑ Unknown

13. Does the patient have either of the following? ***ACTION REQUIRED: Attach supporting medical records.***
❑ Presence of cutaneous or tendinous xanthomas before the age of 10 years
❑ An untreated LDL-C level of greater than or equal to 190 mg/dL in both parents
❑ Neither - The patient does not meet any of the criteria listed above
❑ Unknown

14. Does the patient have known LDL-receptor negative mutations in both alleles?
If Yes, skip to #18 ❑ Yes ❑ No

15. Prior to initiation of treatment with the requested medication, is/was the patient receiving a combination lipid-lowering regimen consisting of a high-intensity statin, ezetimibe, and proprotein convertase subtilisin/kexin type 9 (PCSK9) directed therapy? ***ACTION REQUIRED: Attach medical records confirming lipid lowering therapy.***
❑ Yes ❑ No

16. 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 ❑ No *If No, skip to #18*

17. Prior to initiation of treatment with the requested medication, what is/was the patient's treated LDL-C level in mg/dL? ***ACTION REQUIRED: For initial requests, attach medical records indicating the current LDL-C level. For continuation of therapy requests, 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.*** _____ mg/dL *Skip to #19*

18. Prior to initiation of treatment with the requested medication, what is/was the patient's LDL-C level in mg/dL? ***ACTION REQUIRED: For initial requests, attach medical records indicating the current LDL-C level. For continuation of therapy requests, 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.*** _____ mg/dL

19. Will the patient continue to receive concomitant lipid-lowering therapy? ***ACTION REQUIRED: Attach medical records confirming lipid lowering therapy.*** ❑ Yes ❑ No

20. Is the patient currently receiving treatment with the requested medication?
❑ Yes ❑ No *If No, no further questions*

21. 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 ❑ Unknown

22. Has the patient achieved or maintained at least 20% LDL-C reduction from baseline? ❑ 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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