PRALUENT

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 thr 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 INFORMATION	**PRESCRIBER INFORMATION**
Date: _____	**Name:** _____
Name: _____	**Office Telephone:** _____
ID: _____	**Office Fax:** _____
Date of Birth: _____	**Specialty:** _____
Request Initiated For: _____	**NPI#:** _____

CRITERIA QUESTIONS

1. What is the patient's diagnosis? _____
2. What is the ICD-10 code? _____
3. Is this a request for continuation of therapy with a PCSK9 inhibitor? *If Yes, no further questions* ❑ Yes ❒ ❑ No
4. Does the patient meet all of the following? *If Yes, no further questions* ❒❑ Yes ❒ ❑ No
   a. The patient has a history of clinical atherosclerotic cardiovascular disease (ASCVD) or has experienced a cardiovascular event
   b. The patient has a current LDL-C level of greater than or equal to 70 mg/dL
   c. The patient is receiving maximally tolerated statin therapy or is statin intolerant
5. Does the patient meet all of the following? *If Yes, no further questions* ❒❑ Yes ❒ ❑ No
   a. The patient had an untreated (before any lipid-lowering therapy) LDL-C level greater than or equal to 190 mg/dL
   b. The patient has a current LDL-C level of greater than or equal to 100 mg/dL
   c. The patient is receiving maximally tolerated statin therapy or is statin intolerant
6. Does the patient meet all of the following? ❑ Yes ❒ ❑ No
   a. The patient is less than 18 years of age and had an untreated (before any lipid-lowering therapy) LDL-C level greater than or equal to 160 mg/dL
   b. The patient has heterozygous familial hypercholesterolemia (HeFH) or homozygous familial hypercholesterolemia (HoFH)
   c. The patient has a current LDL-C level of greater than or equal to 100 mg/dL
   d. The patient is receiving maximally tolerated statin therapy or is statin intolerant

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 Prior Authorization Fax: 1-866-249-6155