CareFirst
The CareFirst BlueCross BlueShield family of health care plans

CVS/caremark

Praluent

Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-866-249-6155

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.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

1. What drug is being prescribed? ❑ Praluent ❑ Other _____
2. What is the prescribed dose **and** frequency? _____
3. For which of the following situations is Praluent being prescribed?
   ❑ Patient with prior history of clinical atherosclerotic cardiovascular disease (ASCVD) or event without familial hypercholesterolemia
   ❑ Patient with heterozygous familial hypercholesterolemia (HeFH) with ASCVD or event
   ❑ Patient with heterozygous familial hypercholesterolemia (HeFH) without ASCVD or event
   ❑ Other _____
4. What is the ICD-10 code? _____
5. What is the patient's age? _____
6. What is the prescriber's specialty? _____
7. ***If the patient is currently receiving a PCSK9 inhibitor (e.g, Repatha, Praluent), please document the following information:***
   - Total duration of treatment (approximate duration is acceptable): _____
   - Date of the last dose administered: _____
   - Approving health plan/pharmacy benefit manager: _____
   - Date of the prior authorization/approval: _____
   - Prior authorization/approval number (if any): _____
8. Has the patient received a laboratory testing of cholesterol recently (within the last 90 days)? ❑ Yes ❑ No
9. ***ACTION REQUIRED:*** Is the laboratory report attached? ❑ Yes ❑ No
10. What is the **baseline** (i.e., before treatment with any lipid-lowering treatment) low-density lipoprotein cholesterol (LDL-C) level? _____ mg/dL
11. What is the **current** LDL-C level? _____ mg/dL Date of lab: _____
12. What is the **current** triglyceride level? _____ mg/dL Date of lab: _____

13. Has the patient received, within the last 120 days, at least a 3-month supply of any of the following medications through a prior authorization process for a pharmacy or medical benefit?
    ❑ Praluent (alirocumab), *continue to section A*
    ❑ Repatha (evolocumab), *no further questions*
    ❑ No, *continue to section B*

Complete the following section(s) based on the use of lipid lowering treatment and reason for requesting therapy.

Section A: Continuation of Treatment with Praluent

14. What was the percentage reduction in LDL-C level? _____ %

15. How much was the absolute reduction in LDL-C level? _____ mg/dL

16. What was the absolute LDL-C level reduced to? _____ mg/dL

17. ***ACTION REQUIRED:*** Is documentation indicating the reduction in LDL-C levels or maintenance of reduced LDL-C levels (i.e., chart notes, medical record, and/or laboratory reports) attached? ❑ Yes ❑ No

Section B: Initiation of Treatment

18. Does the patient have a history of clinical atherosclerotic cardiovascular disease (ASCVD) or cardiovascular event (eg, acute coronary syndrome, myocardial infarction, stroke of presumed atherosclerotic origin)?
    ❑ Yes, ***please specify:*** _____ ❑ No

19. Does the patient have a definite diagnosis of familial hypercholesterolemia (FH) confirmed by ONE of the following criteria sets?
    ❑ An LDL-receptor mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation
    ❑ Total cholesterol greater than (>) 290 mg/dL or LDL-C greater than (>) 190 mg/dL
    plus tendon xanthoma in patient, first-degree relative (brother, sister, parent, child) or second-degree relative (grandparent, uncle, aunt)
    ❑ Dutch Lipid Clinic Network Criteria: Total score greater than (>) 8 (i.e., definite familial hypercholesterolemia)*
    ❑ No – The patient does not meet any of the criteria listed above

Section C: Current or Previous Lipid Lowering Treatment

20. Document previous/current therapies, dose/frequency, duration and outcome of previously prescribed medications.
    Attach supporting documentation indicating patient's medication history.
    Outcome examples include: intolerance, contraindication or currently receiving medication

    A) Drug: _____ Dose/Frequency: _____ Duration: _____
    Outcome: _____
    B) Drug: _____ Dose/Frequency: _____ Duration: _____
    Outcome: _____
    C) Drug: _____ Dose/Frequency: _____ Duration: _____
    Outcome: _____
    D) Drug: _____ Dose/Frequency: _____ Duration: _____
    Outcome: _____

21. Was/Is the patient adherent to his/her lipid-lowering treatment regimen? ❑ Yes ❑ No

22. Has the patient experienced any of the following adverse reactions to a previous treatment with statin?
    ❑ Statin-associated increase in creatine kinase (CK) level to greater than or equal to 10 times upper limit of normal (ULN)
    ❑ Statin-associated rhabdomyolysis (i.e., CK level greater than 10,000 IU/L or accompanied by significant elevation in creatinine level)
    ❑ No – None of the above, *skip to #24*

23. ***ACTION REQUIRED:*** If applicable, is the documentation indicating the CK level elevation and/or rhabdomyolysis (patient's chart, medical record or laboratory report) attached? ❑ Yes ❑ No ❑ Not applicable

24. Did the patient experience intolerable and persistent (i.e., at least for 2 weeks) muscle symptoms (e.g., muscle pain, weakness, cramps)? ❑ Yes ❑ No

25. Has the patient undergone statin re-challenges with at least two statins? ❑ Yes ❑ No

26. Did the re-challenges include Crestor (rosuvastatin) or Lipitor (atorvastatin)?
❑ Yes ❑ No *If No, skip to #28*

27. ***ACTION REQUIRED:*** Is documentation of the statin re-challenge and established causal relationship between the statin and the muscle symptoms (i.e., patient's chart or medical record) attached? ❑ Yes ❑ No

28. Does the patient have a contraindication to statins? ❑ Yes ❑ No

29. Which of the following contraindications does the patient have?
❑ Active liver disease, including unexplained persistent elevations in hepatic transaminase levels due to statin use (e.g., ALT greater than or equal to 3 times upper limit of normal) - ***ACTION REQUIRED:*** Attach documentation.
❑ Currently pregnant
❑ May become pregnant
❑ Nursing mother
❑ None of the above

30. ***ACTION REQUIRED:*** If applicable, is documentation indicating persistent elevations in hepatic transaminase levels (i.e., patient's chart, medical record or laboratory report) attached? ❑ Yes ❑ No ❑ Not applicable

31. Is the patient taking Zetia (ezetimibe)? ❑ Yes ❑ No

32. Does the patient have a contraindication to Zetia (ezetimibe)? ❑ Yes ❑ No

33. Please specify the contraindication to Zetia (ezetimibe): _____

34. ***ACTION REQUIRED:*** Is documentation indicating the contraindication to Zetia (ezetimibe) (i.e., patient's chart, medical record) attached? ❑ Yes ❑ No

****Please see next page for Dutch Lipid Clinic Network Criteria for FH in adults.***

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)**

Table. Dutch Lipid Clinic Network Criteria for FH in adults* (Circle the applicable items)

	Score *
Family history	
First-degree relative** with known premature coronary and/or vascular disease (men <55 years, women <60 years) **OR**	1
First-degree relative** with known LDL cholesterol >95th percentile by age and gender **OR**	1
First-degree relative** with tendon xanthoma and/or corneal arcus	2
Clinical history	
Patient with premature (men <55 years, women <60 years) coronary artery disease **OR**	2
Patient with premature (men <55 years, women <60 years) cerebral or peripheral vascular disease	1
Physical examination	
Tendon xanthoma **OR**	6
Corneal arcus before age 45 years	4
LDL-cholesterol	
>325 mg/dL	8
251–325 mg/dL	5
191–250 mg/dL	3
155–190 mg/dL	1
DNA analysis	
Causative mutation shown in the LDLR, APOB or PCSK9 genes	8
Total score*	

*Use of the diagnostic algorithm: per group only one score, the highest applicable, can be chosen.
**First-degree relative: brother, sister, parent, child.