



Repatha

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.

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PATIENT INFORMATION

Date: _____
Name: _____
ID: _____
Date of Birth: _____
Request Initiated For: _____

PRESCRIBER INFORMATION

Name: _____
Office Telephone: _____
Office Fax: _____
Specialty: _____
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

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

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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)

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