Evkeeza

CareFirst 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:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering 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.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

What is the ICD-10 code? _____

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

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Site of Service Questions:

A. Where will this drug be administered?
- ❑ Ambulatory surgical, *skip to Clinical Criteria Questions*
- ❑ Home infusion, *skip to Clinical Criteria Questions*
- ❑ Off-campus Outpatient Hospital, *Continue to B*
- ❑ On-campus Outpatient Hospital, *Continue to B*
- ❑ Physician office, *skip to Clinical Criteria Questions*
- ❑ Pharmacy, *skip to Clinical Criteria Questions*

B. Is the patient less than 14 years of age?
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to C*

C. Is this request to continue previously established treatment with the requested medication? ***Action Required: If No, please attach supporting clinical documentation.***
- ❑ Yes - This is a continuation of an existing treatment., *Continue to D*
- ❑ No - This is a new therapy request (patient has not received requested medication in the last 6 months)., *skip to Clinical Criteria Questions*

D. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of the infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to E*

E. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation.
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to F*

F. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to G*

G. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to H*

H. Are ***all*** alternative infusion sites (pharmacy, physician office, ambulatory care, etc.) **greater than** 30 miles from the patient's home? ***ACTION REQUIRED: If Yes, please attach supporting documentation.***
- ❑ Yes, *continue to Clinical Criteria Questions*
- ❑ No, *continue to Clinical Criteria Questions*

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Criteria Questions:

1. What is the diagnosis?

❒ Homozygous familial hypercholesterolemia (HoFH), *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

2. Does the patient possess variant in two low-density lipoprotein receptor (LDLR) alleles? ***ACTION REQUIRED***: If yes, attach genetic testing or supporting medical records.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 8*

❒ No or unknown, *Continue to 3*

3. 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***: If yes, attach genetic testing or supporting medical records.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 8*

❒ No or unknown, *Continue to 4*

4. Does the patient have compound heterozygosity or homozygosity for variants in the gene encoding low-density lipoprotein receptor adaptor protein 1 (LDLRAP1)? ***ACTION REQUIRED***: If yes, attach genetic testing or supporting medical records.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 8*

❒ No or unknown, *Continue to 5*

5. What was the patient's untreated (before treatment with any lipid-lowering therapy) LDL-C (low-density lipoprotein-cholesterol) level? Indicate in milligrams per deciliter (mg/dL). ***ACTION REQUIRED***: Attach supporting medical records.

❒ Greater than 400 mg/dL _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 6*

❒ Less than or equal to 400 mg/dL _____, *Continue to 6*

❒ Unknown, *Continue to 6*

6. Does the patient have presence of cutaneous or tendinous xanthomas before the age of 10 years? ***ACTION REQUIRED***: If yes, attach supporting medical records.

❒ Yes, *Continue to 8*

❒ No, *Continue to 7*

7. Do both of the patient's parents have an untreated (before treatment with any lipid-lowering therapy) LDL-C level of greater than or equal to 190 mg/dL? ***ACTION REQUIRED***: If yes, attach supporting medical records.

❒ Yes, *Continue to 8*

❒ No, *Continue to 8*

8. Prior to initiation of treatment with the requested drug, what is/was the patient's treated LDL-C (low-density lipoprotein-cholesterol) level? Indicate in milligrams per deciliter (mg/dL). ***ACTION REQUIRED***: For initial requests, attach medical records indicating the current LDL-C level. The level must be dated within the six months preceding the authorization request for the requested drug. For continuation of therapy requests, attach medical records of LDL-C level prior to initiation of treatment with the requested drug.

❒ Greater than or equal to 70 mg/dL _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 12*

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❒ Greater than or equal to 55 mg/dL to less than 70 mg/dL _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 9*

❒ Less than 55 mg/dL _____, *No further questions*

❒ Unknown, *No further questions*

9. Prior to initiation of treatment with the requested drug, does/did the patient have a history of a clinical atherosclerotic cardiovascular disease (ASCVD) event?

❒ Yes, *Continue to 10*

❒ No, *Continue to 11*

10. Which of the following manifestations of clinical atherosclerotic cardiovascular disease (ASCVD) has/had the patient experienced? ***ACTION REQUIRED***: Attach chart notes confirming clinical atherosclerotic cardiovascular disease.

❒ Acute coronary syndrome(s) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 12*

❒ Myocardial infarction ***ACTION REQUIRED****: Submit supporting documentation, Continue to 12*

❒ Stable or unstable angina ***ACTION REQUIRED****: Submit supporting documentation, Continue to 12*

❒ Coronary or other arterial revascularization procedure (e.g., percutaneous coronary intervention [PCI], coronary artery bypass graft [CABG] surgery) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 12*

❒ Stroke of presumed atherosclerotic origin ***ACTION REQUIRED****: Submit supporting documentation, Continue to 12*

❒ Transient ischemic attack (TIA) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 12*

❒ Non-cardiac peripheral arterial disease (PAD) of presumed atherosclerotic origin (e.g., carotid artery stenosis, lower extremity PAD) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 12*

❒ Obstructive coronary artery disease (defined as fifty percent or greater stenosis on cardiac computed tomography angiogram or catheterization) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 12*

❒ Coronary Artery Calcium (CAC) score of greater than or equal to 300 ***ACTION REQUIRED****: Submit supporting documentation, Continue to 12*

❒ Other, please specify. _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 11*

11. Prior to initiation of treatment with the requested drug, does/did the patient have major ASCVD risk factors (e.g., 65 years of age or older, familial hypercholesterolemia, diabetes, chronic kidney disease, history of congestive heart failure)?

❒ Yes, *Continue to 12*

❒ No, *Continue to 12*

12. What is the patient's age in years?

❒ Less than 5 years of age, *No further questions*

❒ 5 years to less than 7 years of age, *Continue to 18*

❒ 7 years to less than 10 years of age, *Continue to 15*

❒ 10 years of age or older, *Continue to 13*

13. Prior to initiation of treatment with the requested drug, is/was the patient receiving stable treatment with at least 3 lipid-lowering therapies (for example, statins, ezetimibe, proprotein convertase subtilisin/kexin type 9 [PCSK9] directed therapy) at the maximally tolerated dose? ***ACTION REQUIRED***: If yes, attach chart notes, medical record documentation, or claims history confirming the lipid-lowering therapy.

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❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Will the patient continue to receive concomitant therapy with 3 lipid-lowering agents (e.g., statins, ezetimibe, proprotein convertase subtilisin/kexin type 9 [PCSK9] directed therapy) at the maximally tolerated dose? ***ACTION REQUIRED***: If yes, attach chart notes, medical record documentation, or claims history confirming the concomitant lipid-lowering therapy.
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

15. Prior to initiation of treatment with the requested drug, is/was the patient receiving stable treatment with at least one maximally tolerated lipid-lowering therapy (e.g., statins, LDL apheresis)? ***ACTION REQUIRED***: If yes, attach chart notes, medical record documentation, or claims history confirming the lipid-lowering therapy.
❒ Yes, *Continue to 16*
❒ No, *Continue to 17*

16. Will the patient continue to receive concomitant therapy with one maximally tolerated lipid-lowering therapy (e.g., statins, LDL apheresis)? ***ACTION REQUIRED***: If yes, attach chart notes, medical record documentation, or claims history confirming the lipid-lowering therapy.
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

17. Does the patient have an intolerance or contraindication to other lipid-lowering therapies? ***ACTION REQUIRED***: If yes, attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. Is the patient currently receiving treatment with the requested drug?
❒ Yes, *Continue to 19*
❒ No, *No Further Questions*

19. Does the patient have a current LDL-C (low-density lipoprotein-cholesterol) level drawn in the past 6 months? If yes, please indicate the current LDL-C level in mg/dL. ***ACTION REQUIRED***: Attach chart notes indicating the current LDL-C level. The LDL-C level must be dated within the six months preceding the authorization request.
❒ Yes - Current LDL-C level: _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 20*

❒ No or Unknown, *Continue to 20*

20. Has the patient achieved or maintained an LDL-C reduction as evidenced by either of the following?

❒ LDL-C is now at goal, *Continue to 21*

❒ At least 30% reduction of LDL-C from baseline, *Continue to 21*

❒ None of the above, *Continue to 21*

21. What is the patient's age in years?

❒ Less than 5 years of age, *No further questions*

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❒ 5 years to less than 7 years of age, *No further questions*

❒ 7 years to less than 10 years of age, *Continue to 22*

❒ 10 years of age or older, *Continue to 24*

22. Is the patient currently receiving concomitant lipid-lowering therapy at the maximally tolerated dose? ***ACTION REQUIRED***: If yes, attach chart notes, medical record documentation, or claims history confirming the lipid-lowering therapy.
❒ Yes, *No Further Questions*
❒ No, *Continue to 23*

23. Does the patient have an intolerance or contraindication to other lipid-lowering therapies? ***ACTION REQUIRED***: If yes, attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

24. Is the patient currently receiving concomitant lipid-lowering therapy at the maximally tolerated dose? ***ACTION REQUIRED***: If yes, attach chart notes, medical record documentation, or claims history confirming the lipid-lowering therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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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