Leqvio

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.

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:** _____

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*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

What is the ICD-10 code? _____

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

 Leqvio SGM 5116-A – 05/2025.

Criteria Questions:

1. What is the diagnosis?
❒ Primary hyperlipidemia including heterozygous familial hypercholesterolemia (HeFH), *Continue to 2*
❒ Other, please specify. _____, *Continue to 2*

2. Is the patient currently receiving treatment with the requested drug?
❒ Yes, *Continue to 3*
❒ No, *Continue to 11*

3. 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: _____mg/dL, ***ACTION REQUIRED****: Submit supporting documentation, Continue to 4*
❒ No or Unknown, *Continue to 4*

4. Has the patient achieved or maintained an LDL-C reduction (e.g., LDL-C is now at goal, robust lowering of LDL-C) as the result of treatment with the requested drug?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Is the patient currently receiving concomitant statin therapy?
❒ Yes, *Continue to 6*
❒ No, *Continue to 7*

6. Will the patient continue to receive concomitant statin therapy?
❒ Yes, *No Further Questions*
❒ No, *Continue to 7*

7. Did the patient score a 7 or higher on the Statin-Associated Muscle Symptom Clinical Index (SAMS-CI) and failed statin rechallenge? ***ACTION REQUIRED***: If Yes, attach chart notes or medical record documentation confirming the SAMS-CI score and failed rechallenge with statin therapy.
❒ Yes, *No Further Questions*
❒ No, *Continue to 8*

8. Did the patient experience a statin-associated increase in creatine kinase (CK) level of greater than or equal to 10 times the upper limit of normal (ULN) during previous treatment with a statin? ***ACTION REQUIRED***: If Yes, attach chart notes or medical record documentation confirming the CK level.
❒ Yes, *No Further Questions*
❒ No, *Continue to 9*

9. Did the patient experience statin-associated muscle symptoms with increase in creatine kinase (CK) level of greater than 3 times the upper limit of normal (ULN) during previous treatment with a statin? ***ACTION REQUIRED***: If Yes, attach chart notes or medical record documentation of muscle symptoms and confirming the CK level.
❒ Yes, *No Further Questions*
❒ No, *Continue to 10*

10. Does the patient have any of the following contraindications to statins? ***ACTION REQUIRED***: If Yes, attach chart notes or medical record documentation confirming the contraindication.

❒ Yes - Active liver disease, including unexplained persistent elevations in hepatic transaminase levels (e.g., alanine transaminase [ALT] level greater than or equal to 3 times upper limit of normal) ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Yes - Currently pregnant or planning pregnancy ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Yes - Breastfeeding ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ None of the above, *No further questions*

11. Does the patient have a history of clinical atherosclerotic cardiovascular disease (ASCVD)?
❒ Yes, *Continue to 12*
❒ No, *Continue to 16*

12. Which of the following manifestations of clinical atherosclerotic cardiovascular disease (ASCVD) has the patient experienced? ***ACTION REQUIRED***: Attach chart notes confirming clinical atherosclerotic cardiovascular disease.
❒ Acute coronary syndrome(s) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*
❒ Myocardial infarction ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*
❒ Stable or unstable angina ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*
❒ 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 13*
❒ Stroke of presumed atherosclerotic origin ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*
❒ Transient ischemic attack (TIA) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*
❒ 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 13*
❒ 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 13*
❒ Coronary Artery Calcium (CAC) score of greater than or equal to 300 ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*
❒ Other, please specify. _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*

13. What is the current LDL-C (low-density lipoprotein-cholesterol) 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.
❒ Greater than or equal to 70 mg/dL _____mg/dL, ***ACTION REQUIRED****: Submit supporting documentation, Continue to 19*
❒ Greater than or equal to 55 mg/dL to less than 70 mg/dL _____mg/dL, ***ACTION REQUIRED****: Submit supporting documentation, Continue to 14*
❒ Less than 55 mg/dL _____mg/dL, *No further questions*
❒ Unknown, *No further questions*

14. Has the patient experienced multiple atherosclerotic cardiovascular disease (ASCVD) events? ***ACTION REQUIRED***: If yes, attach chart notes confirming ASCVD events.
❒ Yes - Acute coronary syndrome(s) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 19*
❒ Yes - Myocardial infarction ***ACTION REQUIRED****: Submit supporting documentation, Continue to 19*
❒ Yes - Stable or unstable angina ***ACTION REQUIRED****: Submit supporting documentation, Continue to 19*
❒ Yes - 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 19*

❒ Yes - Stroke of presumed atherosclerotic origin ***ACTION REQUIRED****: Submit supporting documentation, Continue to 19*
❒ Yes - Transient ischemic attack (TIA) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 19*
❒ Yes - 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 19*
❒ Yes - 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 19*
❒ Yes - Coronary Artery Calcium (CAC) score of greater than or equal to 300 ***ACTION REQUIRED****: Submit supporting documentation, Continue to 19*
❒ Yes - Other, please specify. _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 15*
❒ No, *Continue to 15*

15. Does the patient have multiple high-risk conditions (e.g., 65 years of age or older, familial hypercholesterolemia, diabetes, chronic kidney disease, history of congestive heart failure)?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

16. What is the patient's untreated (before any lipid-lowering therapy) LDL-C (low-density lipoprotein-cholesterol) level in mg/dL? ***ACTION REQUIRED***: Attach chart notes indicating the untreated LDL-C level.
❒ Greater than or equal to 190 mg/dL _____mg/dL, ***ACTION REQUIRED****: Submit supporting documentation, Continue to 17*
❒ Less than 190 mg/dL _____md/dL, *Continue to 17*
❒ Unknown, *Continue to 17*

17. Are there any secondary causes that could explain the elevated untreated LDL-C?
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. What is 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.
❒ Greater than or equal to 100 mg/dL _____mg/dL, ***ACTION REQUIRED****: Submit supporting documentation, Continue to 19*
❒ Less than 100 mg/dL _____mg/dL, *Continue to 19*
❒ Unknown, *Continue to 19*

19. Is the patient receiving a high-intensity statin dose daily, such as rosuvastatin (Crestor) 20 mg daily or atorvastatin (Lipitor) 40 mg daily?
❒ Yes, *Continue to 20*
❒ No, *Continue to 21*

20. Has the patient received this dose for at least 3 months?
❒ Yes, *Continue to 24*
❒ No, *Continue to 21*

21. Does the patient have either of the following?
❒ An intolerance to a high-intensity statin, *Continue to 22*
❒ A contraindication to statin therapy, *Continue to 25*
❒ None of the above, *No further questions*

22. Is the patient receiving a moderate-intensity statin dose daily, such as atorvastatin (Lipitor) 20 mg or equivalent?
❒ Yes, *Continue to 23*
❒ No, *Continue to 25*

23. Has the patient received this dose for at least 3 months?
❒ Yes, *Continue to 24*
❒ No, *Continue to 25*

24. Will the patient continue to receive concomitant statin therapy?
❒ Yes, *Continue to 29*
❒ No, *Continue to 25*

25. Did the patient score a 7 or higher on the Statin-Associated Muscle Symptom Clinical Index (SAMS-CI) and failed statin rechallenge? ***ACTION REQUIRED***: If Yes, attach chart notes or medical record documentation confirming the SAMS-CI score and failed rechallenge with statin therapy.
❒ Yes, *Continue to 29*
❒ No, *Continue to 26*

26. Did the patient experience a statin-associated increase in creatine kinase (CK) level of greater than or equal to 10 times the upper limit of normal (ULN) during previous treatment with a statin? ***ACTION REQUIRED***: If Yes, attach chart notes or medical record documentation confirming the CK level.
❒ Yes, *Continue to 29*
❒ No, *Continue to 27*

27. Did the patient experience statin-associated muscle symptoms with increase in creatine kinase (CK) level of greater than 3 times the upper limit of normal (ULN) during previous treatment with a statin? ***ACTION REQUIRED***: If Yes, attach chart notes or medical record documentation of muscle symptoms and confirming the CK level.
❒ Yes, *Continue to 29*
❒ No, *Continue to 28*

28. Does the patient have any of the following contraindications to statins? ***ACTION REQUIRED***: If Yes, attach chart notes or medical record documentation confirming the contraindication.
❒ Yes - Active liver disease, including unexplained persistent elevations in hepatic transaminase levels (e.g., alanine transaminase [ALT] level greater than or equal to 3 times upper limit of normal) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 29*
❒ Yes - Currently pregnant or planning pregnancy ***ACTION REQUIRED****: Submit supporting documentation, Continue to 29*
❒ Yes - Breastfeeding ***ACTION REQUIRED****: Submit supporting documentation, Continue to 29*
❒ None of the above, *Continue to 29*

29. Is a loading dose prescribed?
❒ 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)**

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

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