PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 5/13/2025
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: **Patient Phone:** **Physician Name:**
_____ **NPI#:** _____ **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
Drug Name (specify drug) _____
Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1. What is the diagnosis?

   Homozygous familial hypercholesterolemia (HoFH) (If checked, go to 2) ☐

   Other, please specify. (If checked, no further questions) ☐

   _____

2. Does the patient possess variant in two low-density lipoprotein receptor (LDL-R) alleles? ACTION REQUIRED: If yes, attach genetic testing or supporting medical records. Yes (If checked, go to 8) ☐

   No or unknown (If checked, go to 3) ☐

   ACTION REQUIRED: Submit supporting documentation

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 (If checked, go to 8) ☐

   No or unknown (If checked, go to 4) ☐

   ACTION REQUIRED: Submit supporting documentation

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 (If checked, go to 8) ☐

   No or unknown (If checked, go to 5) ☐

   ACTION REQUIRED: Submit supporting documentation

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

Greater than 400 mg/dL (If checked, go to 6) ☐

Less than or equal to 400 mg/dL (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

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. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

7. Do both of the patient's parents have an untreated (before treatment with any lipidlowering therapy) low-density lipoprotein cholesterol (LDL-C) level of greater than or equal to 190 mg/dL? ACTION REQUIRED: If yes, attach supporting chart notes or medical records. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

8. Prior to initiation of treatment with the requested drug, what is/was the patient's treated low-density lipoprotein cholesterol (LDL-C) 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 (If checked, go to 12) ☐

Greater than or equal to 55 mg/dL to less than 70 mg/dL (If checked, go to 9) ☐

Less than 55 mg/dL (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

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? **Y** ☐ **N** ☐

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) (If checked, go to 12) ☐

Myocardial infarction (If checked, go to 12) ☐

Stable or unstable angina (If checked, go to 12) ☐

Coronary or other arterial revascularization procedure (e.g., percutaneous coronary intervention [PCI], coronary artery bypass graft [CABG] surgery) (If checked, go to 12) ☐

Stroke of presumed atherosclerotic origin (If checked, go to 12) ☐

Transient ischemic attack (TIA) (If checked, go to 12) ☐

Non-cardiac peripheral arterial disease (PAD) of presumed atherosclerotic origin (e.g., carotid artery stenosis, lower extremity PAD) (If checked, go to 12) ☐

Obstructive coronary artery disease (defined as fifty percent or greater stenosis on cardiac computed tomography angiogram or catheterization) (If checked, go to 12) ☐

Coronary Artery Calcium (CAC) score of greater than or equal to 300 (If checked, go to 12) ☐

Other, please specify. (If checked, go to 11) ☐

ACTION REQUIRED: Submit supporting documentation

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)? **Y** ☐ **N** ☐

12. 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. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐☐☐☐ I attest that the

13. Will the patient continue to receive concomitant lipid-lowering therapy? ACTION REQUIRED: Attach medical records confirming concomitant lipid-lowering therapy. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N**

14. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N**

15. Does the patient have a current low-density lipoprotein cholesterol (LDL-C) level drawn in the past 6 months? If yes, please indicate the current LDL-C in mg/dL. ACTION REQUIRED: Attach medical records 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: (If checked, go to 16) ☐

No or unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

16. Has the patient achieved or maintained at least 20% low-density lipoprotein cholesterol (LDL-C) reduction from baseline? **Y** ☐ **N**

medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date