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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:** 3/16/2026
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?
 - Familial chylomicronemia syndrome (FCS) (If checked, go to 2)
 - Other, please specify. (If checked, no further questions)
 - _____
2. Is the patient currently taking Tryngolza? Y N
3. Is the patient an adult (18 years of age or older)? Y N
4. Is the requested drug being prescribed by or in consultation with a cardiologist, endocrinologist, lipid specialist, geneticist, or a prescriber specialized in the treatment of familial chylomicronemia syndrome (FCS)? Y N
5. Is the patient currently receiving therapy with the requested drug? Y N
6. Has the patient demonstrated a positive clinical response with the requested drug? (e.g., reduction in triglyceride level from baseline, reduction in episodes of acute pancreatitis). ACTION REQUIRED: If yes, please attach chart notes or medical record documentation supporting positive clinical response. ACTION REQUIRED: Submit supporting documentation Y N
7. Was genetic testing performed to confirm the diagnosis of familial chylomicronemia syndrome (FCS)?
 - Yes (If checked, go to 8)
 - No (If checked, no further questions)
 - Unknown (If checked, no further questions)
8. Has the diagnosis of familial chylomicronemia syndrome (FCS) been confirmed by genetic testing? (i.e., biallelic pathogenic variants in FCS-causing genes [e.g., LPL, GPIHBP1, APOA5, APO2, LMF1, GPD1, CREB3L3]). ACTION REQUIRED: If yes, please attach genetic test(s) confirming diagnosis of FCS.
 - Yes (If checked, go to 11)
 - No (If checked, go to 9)
 - ACTION REQUIRED: Submit supporting documentation

9. What is the North American familial chylomicronemia syndrome (NAFCS) score? ACTION REQUIRED: Please attach chart notes or medical record documentation of NAFCS score.
- Greater than or equal to 45 (If checked, go to 11)
- Less than 45 (If checked, go to 10)
- Unknown (If checked, go to 10)
- ACTION REQUIRED: Submit supporting documentation
10. What is the Moulin score? ACTION REQUIRED: Please attach chart notes or medical record documentation of Moulin score.
- Greater than or equal to 10 (If checked, go to 11)
- Less than 10 (If checked, no further questions)
- Unknown (If checked, no further questions)
- ACTION REQUIRED: Submit supporting documentation
11. What is the patient's fasting triglycerides (TG) level? ACTION REQUIRED: Please attach laboratory tests or medical record documentation of fasting TG level.
- Greater than or equal to 880 mg/dL (If checked, go to 12)
- Less than 880 mg/dL (If checked, no further questions)
- Unknown (If checked, no further questions)
- ACTION REQUIRED: Submit supporting documentation
12. Is the patient currently receiving a very-low fat diet? (e.g., less than 20 to 30 grams of total fat per day, 10% to 15% of calories of fat) Y N

I attest that the 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

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.