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:** 3/31/2025

**Patient ID:** _____ **Patient Date Of Birth:** _____

**Patient Group No:** _____ **Patient Phone:** _____ **Physician Name:**

_____ **NPI#:** **Specialty:**

**Physician Office Address:** _____ **Physician Office Telephone:**

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**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 receiving therapy with the requested drug? **Y** ☐ **N** ☐

3. Has the patient demonstrated a positive clinical response with the requested drug? (e.g., reduction in fasting triglyceride level from baseline, reduction in episodes of acute pancreatitis). ACTION REQUIRED: If yes, please attach laboratory tests or medical record documentation supporting positive clinical response. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

4. 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, attach genetic test(s) confirming diagnosis of FCS. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

5. What is the patient's fasting triglyceride (TG) level? ACTION REQUIRED: Attach laboratory tests or medical record documentation of fasting TG level.

   Greater than or equal to 880 mg/dL (If checked, go to 6) ☐

   Less than 880 mg/dL (If checked, no further questions) ☐

6. 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 per day 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**

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