

Member Name: {{MEMFIRST}} {{MEMLAST}} DOB: {{MEMBERDOB}} PA Number: {{PANUMBER}}



{{PANUMCODE}}

## Cholbam

### 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 1-866-249-6155.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506**. 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:** {{MEMFIRST}} {{MEMLAST}} **Date:** {{TODAY}}  
**Patient's ID** {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}  
**Physician's Name:** {{PHYFIRST}} {{PHYLAST}}  
**Specialty:** \_\_\_\_\_, **NPI#:** \_\_\_\_\_  
**Physician Office Telephone:** {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}  
**Request Initiated For:** {{DRUGNAME}}

1. What is the diagnosis?  
 Bile acid synthesis disorder due to single enzyme defect (SED)  
 Peroxisomal disorder (PD), including Zellweger spectrum disorders  
 Other \_\_\_\_\_
2. What is the ICD-10 code? \_\_\_\_\_
3. Was the diagnosis confirmed by mass spectrometry or other biochemical testing or genetic testing?  
**ACTION REQUIRED: If Yes, attach supporting chart note(s).**  Yes  No
4. Is this request for continuation of therapy with Cholbam which the patient is receiving via a pharmacy or medical benefit?  Yes  No *If No, skip to #6, if applicable.*
5. Has the patient achieved and maintained improvement in liver function from baseline (i.e. reduced transaminases, reduced bilirubin, no evidence of cholestasis on liver biopsy)?  Yes  No

**Complete the following questions if the patient's diagnosis is peroxisomal disorder (PD), including Zellweger spectrum disorders.**

6. Is Cholbam being requested for use as adjunctive treatment of a peroxisomal disorder?  Yes  No
7. Does the patient exhibit manifestations of liver disease?  Yes  No

***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 Prior Authorization Fax: 1-866-249-6155**

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**CVS Caremark Prior Authorization • 1300 E. Campbell Road • Richardson, TX 75081**

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