



## Evkeeza

### 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.

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**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

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

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**CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062**  
**Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com**

**Criteria Questions:**

1. Does the patient have a documented diagnosis of homozygous familial hypercholesterolemia?  Yes  No
2. What is the ICD-10 code? \_\_\_\_\_
3. Which of the following confirmed the patient's diagnosis of homozygous familial hypercholesterolemia? **Action Required: Attach genetic testing or supporting medical records.**
  - Functional mutation or mutations in both low-density lipoprotein (LDL) receptor alleles *skip to #6*
  - Presence of homozygous or compound heterozygous mutations in apolipoprotein B (APOB) or PCSK9 *skip to #6*
  - Member is double heterozygous (i.e., mutations on different genes [e.g., LDLR/PCSK9]) or homozygous for LDL receptor adaptor protein 1 (LDLRAP1) mutations *skip to #6*
  - None of the above
  - Other
4. What was the patient's untreated (i.e., before treatment with any lipid lowering therapy) total cholesterol level in mg/dL?  
**Action Required: Attach supporting medical records.** \_\_\_\_\_mg/dL  Unknown
5. Which of the following applies to the patient? **Action Required: Attach supporting medical records.**
  - Presence of cutaneous or tendinous xanthomas before the age of 10 years
  - An untreated total cholesterol level of more than 250 mg/dL in both parents
  - Neither- The patient does not meet any of the criteria listed above
6. Prior to initiation of treatment with the requested medication, what was the patient's LDL-C level?  
**Action Required: For initial request, attach medical records indicating the current LDL-C level. For continuation of therapy request, attach medical records of LDL-C level prior to initiation of treatment with the requested medication. The level must be dated within the six months preceding the authorization request of initial treatment with the requested medication.**  
LDL-C level \_\_\_\_\_mg/dL
7. 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, PCSK9 inhibitors) at the maximum tolerated dose? **Action Required: Attach medical records confirming lipid lowering therapy.**  Yes  No
8. Will the patient continue to receive concomitant lipid-lowering therapy?  Yes  No
9. Is the patient currently receiving the requested drug?  Yes  No *If No, no further questions*
10. What is the current LDL-C level? **Action Required: Attach medical records indicating the current treated LDL-C level. The LDL-C level must be dated within the six months preceding the authorization request** LDL-C level \_\_\_\_\_mg/dL
11. Has the patient achieved or maintained an LDL-C reduction as evidenced by either of the following?
  - LDL-C is now at goal
  - At least 40% reduction of LDL-C from baseline
  - None of the above
12. Is the patient currently receiving concomitant lipid-lowering therapy? **Action Required: Attach medical records confirming lipid lowering therapy.**  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)**

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