Praluent (for Maryland only)

Prior Authorization Request

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

PATIENT INFORMATION

Date: _____
Name: _____
ID: _____
Date of Birth: _____
Request Initiated For: _____

PRESCRIBER INFORMATION

Name: _____
Office Telephone: _____
Office Fax: _____
Specialty: _____
NPI#: _____

MARYLAND STEP THERAPY

1. Would the prescriber like to request an override of the step therapy requirement?
   ❑ Yes ❑ No *If No, skip to next section.*
2. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
   ❑ Yes ❑ No ***ACTION REQUIRED: Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***
3. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to next section and complete this form in its entirety.*

INITIAL CRITERIA QUESTIONS

1. Does the patient have a prior history of clinical atherosclerotic cardiovascular disease (ASCVD) or have they experienced a cardiovascular event? *If Yes, skip to #3* ❑ Yes ❒ ❑ No
2. Does the patient have a diagnosis of heterozygous or homozygous familial hypercholesterolemia?
   ❑ Heterozygous familial cholesterolemia (HeFH)
   ❑ Other _____
3. What is the ICD-10 code? _____
4. Is this request for continuation of therapy with Praluent? ❑ Yes ❑ No *If No, skip to next appropriate section.*
5. Is the patient receiving Praluent through samples or a manufacturer's patient assistance program?
   ❑ Yes ❑ No *If No, skip to Continuation of Therapy section*

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD) OR CARDIOVASCULAR EVENT

1. Which of the manifestations of clinical ASCVD has the patient experienced? *List continues on next page*
   - ❑ Acute coronary syndromes
   - ❑ Myocardial infarction
   - ❑ Stable or unstable angina
   - ❑ Coronary or other arterial revascularization procedure (e.g., percutaneous coronary angioplasty [PTCA], coronary artery bypass graft [CABG] surgery)
   - ❑ Stroke of presumed atherosclerotic origin
   - ❑ Transient ischemic attack (TIA)
   - ❑ Non-cardiac peripheral arterial disease of presumed atherosclerotic origin (e.g., carotid artery stenosis)
   - ❑ Obstructive coronary artery disease (defined as fifty percent or greater stenosis on cardiac computed tomography angiogram or catheterization)
   - ❑ Other _____

2. What is the current LDL-C level? _____ mg/dL

Prior Statin Therapy

3. Has the patient received a high-intensity statin dose: Crestor (rosuvastatin) greater than or equal to 20mg daily or Lipitor (atorvastatin) greater than or equal to 40 mg daily? ❑ Yes ❑ No *If No, skip to #5*

4. How long has the patient received treatment with rosuvastatin greater than or equal to 20mg or atorvastatin greater than or equal to 40 mg? _____ months *If greater than or equal to 3 months, skip to #11*

5. Was the patient unable to tolerate a high-intensity statin due to adverse effects? ❑ Yes ❑ No

6. Has the patient received a moderate-intensity statin dose: atorvastatin greater than or equal to 20 mg or equivalent daily? ❑ Yes ❑ No *If No, skip to #8*

7. How long has the patient been receiving treatment with atorvastatin greater than or equal to 20 mg or equivalent daily? _____ months *If greater than or equal to 3 months, skip to #11*

Intolerance and Contraindications

8. Did the patient experience intolerable muscle symptoms (e.g., muscle pain, weakness, and cramps) which persisted for at least for 2 weeks, resolved after discontinuation of the statin, and re-emerged when initiating a different statin? ❑ Yes ❑ No

9. Has the patient experienced a statin-associated increase in creatine kinase (CK) level to greater than or equal to 10 times the upper limit of normal (ULN) during previous treatment with statin? ❑ Yes ❑ No

10. Does the patient have any of the following contraindications to statins?
    - ❑ Active liver disease, including unexplained persistent elevations in hepatic transaminase levels (e.g., ALT greater than or equal to 3 times the ULN)
    - ❑ Currently pregnant
    - ❑ May become pregnant
    - ❑ Nursing mother
    - ❑ None of the above

Other Lipid-Lowering Therapy

11. Is the patient taking ezetimibe (Zetia) 10 mg daily? ❑ Yes ❑ No

12. Does the patient have the following contraindication to ezetimibe?
    - ❑ Prior hypersensitivity reaction (e.g., anaphylaxis, angioedema, rash and urticaria) ❐
    - ❑ Other _____

FAMILIAL HYPERCHOLESTEROLEMIA

Heterozygous Familial Hypercholesterolemia (HeFH)

1. Does the patient have a diagnosis of familial hypercholesterolemia (FH) confirmed by a genetic mutation?
   - ❑ An LDL-receptor mutation, familial defective apoB-100, or a PCSK9 gain-of-function mutation, *skip to #9*
   - ❑ No

2. What is the patient's Dutch Lipid Clinic Network Score? _____ *If greater than or equal to 6, skip to #9*

3. What is the patient's age? _____ years

4. What is the patient's highest recorded total cholesterol? _____ mg/dL

5. What is the patient's highest recorded LDL-C? _____ mg/dL

6. Does the patient, a first degree relative, or a second degree relative, have a tendon xanthoma? *If Yes, skip to #9* ❑ Yes ❑ No

7. Has a patient's first decree relative had a myocardial infarction before the age of 60 or a second degree relative before the age of 50? *If Yes, skip to #9* ❑ Yes ❑ No

8. Has a patient's adult first or second degree relative had a total cholesterol greater than 290 mg/dL or a relative less than 16 years of age had a total cholesterol greater than 260 mg/dL? ❑ Yes ❑ No

9. What is the <u>current</u> LDL-C level? _____ mg/dL

Prior Statin Therapy

10. Has the patient received a high-intensity statin dose: Crestor (rosuvastatin) greater than or equal to 20mg daily or Lipitor (atorvastatin) greater than or equal to 40 mg daily? ❑ Yes ❑ No

11. How long has the patient received treatment with rosuvastatin greater than or equal to 20mg or atorvastatin greater than or equal to 40 mg? _____ months *If greater than or equal to 3 months, skip to #15*

Intolerance and Contraindications

12. Did the patient experience intolerable muscle symptoms (e.g., muscle pain, weakness, and cramps) which persisted for at least for 2 weeks, resolved after discontinuation of the statin, and re-emerged when initiating a different statin? *If Yes, skip to #15* ❑ Yes ❑ No

13. Has the patient experienced a statin-associated increase in creatine kinase (CK) level to greater than or equal to 10 times the upper limit of normal (ULN) during previous treatment with statin? *If Yes, skip to #15* ❑ Yes ❑ No

14. Does the patient have any of the following contraindications to statins?
    ❑ Active liver disease, including unexplained persistent elevations in hepatic transaminase levels (e.g., ALT greater than or equal to 3 times the ULN)
    ❑ Currently pregnant
    ❑ May become pregnant
    ❑ Nursing mother
    ❑ None of the above

Other Lipid-Lowering Therapy

15. Is the patient taking ezetimibe (Zetia) 10 mg daily? ❑ Yes ❑ No

16. Does the patient have the following contraindication to ezetimibe?
    ❑ Prior hypersensitivity reaction (e.g., anaphylaxis, angioedema, rash and urticaria)
    ❑ Other _____

<u>CONTINUATION OF THERAPY</u>

1. Does the patient have a history of clinical ASCVD or have they experienced a cardiovascular event? *If Yes, skip to #3* ❑ Yes ❒ ❑ No

2. Does the patient have a diagnosis of HeFH or HoFH? ❑ Yes ❑ No

3. Has the patient achieved or maintained an LDL-C reduction (e.g., LDL-C is now at goal, robust reduction in LDL-C) as a result of Praluent 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)**