Prescriber Criteria Form Repatha 2025 PA Fax 1774-A v1 010125.docx Repatha (evolocumab) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Repatha (evolocumab).

Drug Name: Repatha (evolocumab)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed to reduce the risk of myocardial infarction, stroke, or coronary revascularization in a patient with established cardiovascular disease? [If yes, then no further questions.]	Yes ◯	No ◯
2	Does the patient have a diagnosis of primary hyperlipidemia (including heterozygous familial hypercholesterolemia [HeFH])? [If yes, then no further questions.]	Yes ◯	No ◯
3	Does the patient have a diagnosis of homozygous familial hypercholesterolemia (HoFH)?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ **Date:**_____