PCSK9 INHIBITORS (PRALUENT/REPATHA) PRIOR AUTHORIZATION REQUEST FORM

PATIENT AND INSURANCE INFORMATION

TODAY'S DATE: ☐☐/☐☐/☐☐☐☐

Patient Name (First):	Last:	Middle Initial:	DOB (mm/dd/yyyy): ☐☐/☐☐/☐☐☐☐

Patient Address:	City:	State:	Zip Code:

Patient Telephone (☐☐☐) ☐☐☐-☐☐☐☐	Member ID Number: ☐☐☐☐☐☐☐☐☐☐	Group Number: ☐☐☐☐☐

PRESCRIBER/CLINIC INFORMATION

Presciber Name:	Presciber NPI#:	Specialty:	Contact Name:

Clinic Name:	Clinic Address:

City:	State:	Zip Code:	Telephone Number: (☐☐☐)-☐☐☐-☐☐☐☐	Secure Fax Number: (☐☐☐)-☐☐☐-☐☐☐☐

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. What is the patient's diagnosis?

☐ **Homozygous familial hypercholesterolemia (HoFH)**

Has the diagnosis been confirmed by any of the following? Please select all that apply.

- ☐ Genetic confirmation of two mutant alleles at the LDLR, Apo-B, PCSK9, ARH adaptor protein 1/LDLRAP1 gene locus
- ☐ Cutaneous or tendon xanthoma before age 10 years
- ☐ History of untreated LDL-C >500 mg/dL (>13 mmol/L) or treated LDL-C ≥300 mg/dL (≥7.76 mmol/L)
- ☐ Untreated elevated cholesterol levels consistent with heterozygous FH in both parents [untreated LDL-C >190 mg/dL (>4.9 mmol/L) or untreated total cholesterol greater than 290 mg/dL (>7.5 mmol/L)]

☐ **Heterozygous familial hypercholesterolemia (HeFH)**

Has the diagnosis been confirmed by any of the following? Please select all that apply.

- ☐ Genetic confirmation of one mutant allele at the LDLR, Apo-B, PCSK9, ARH adaptor protein 1/LDLRAP1 gene locus
- ☐ History of total cholesterol greater than 290 mg/dL (>7.5 mmol/L) or LDL-C greater than 190 mg/dL (>4.9 mmol/L)

Does the patient have a Dutch Lipid Clinic Network Criteria score of greater than 8? ☐ Yes ☐ No

Does the patient have a history of tendon xanthomas? ☐ Yes ☐ No

If no, is there history of tendon xanthomas in any of the following?

- ☐ Patient's first degree relative (i.e. parent, sibling, or child)
- ☐ Patient's second degree relative (e.g. grandparent, uncle, aunt)

☐ **Clinical atherosclerotic cardiovascular disease (ASCVD)**

Has the patient experienced ONE of the following cardiovascular events? Please select all that apply.

- ☐ Acute coronary syndrome
- ☐ Stable or unstable angina
- ☐ Transient ischemic attack (TIA)
- ☐ History of myocardial infarction (MI)
- ☐ Coronary or other arterial revascularization
- ☐ Stroke
- ☐ Peripheral arterial disease presumed to be of atherosclerotic origin

☐ **Other** (ICD code, plus description): _____

Please continue on the next page

Patient Name:	Last:	Middle Initial:	Date of Birth: ☐☐/☐☐/☐☐☐☐

2. Is the patient currently treated with the requested medication? ☐ Yes ☐ No
If yes, when was treatment with the requested medication started? _____

3. Is the patient taking another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor? ☐ Yes ☐ No
If yes, will the agent be discontinued before starting therapy with the requested agent?

4. Is the patient currently being treated with a high-intensity statin (i.e., rosuvastatin 20-40 mg or atorvastatin 40–80mg)? ☐ Yes ☐ No
If yes, is the patient currently adherent (for the past 90 days)? ☐ Yes ☐ No
If no, is the patient intolerant to high-intensity statin therapy statin (i.e., rosuvastatin 20-40 mg AND atorvastatin 40 80mg)? ☐ Yes ☐ No

5. Is the patient currently being treated with a low or moderate statin? ☐ Yes ☐ No
If yes, is the patient currently adherent (for the past 90 days)? ☐ Yes ☐ No
If no, is the patient intolerant (defined as the inability to tolerate the lowest FDA approved starting dose) to at least 2 different statins or does the patient have an FDA labeled contraindication to a statin? ☐ Yes ☐ No

6. Has the patient achieved a 50% reduction in LDL-C from baseline while on a maximally tolerated statin? ☐ Yes ☐ No

7. Has the patient had an LDL-C ≥ 70 mg/dL (≥ 1.81 mmol/L) evaluated with the past 90 days? ☐ Yes ☐ No

8. Please list all reasons for selecting the requested medication, dosing schedule and quantity over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried). _____

_____

_____

9. Please list all medications the patient will use in combination with the requested medication for treatment of this diagnosis.

_____

_____

10. Please list all medications the patient has previously tried and failed for treatment of this diagnosis. _____

_____

_____

For renewal requests:

11. Has the patient shown clinical benefit with the requested agent? ☐ Yes ☐ No

12. Is the patient currently adherent to the requested agent (for the past 90 days)? ☐ Yes ☐ No

Please fax or mail this form to:

Pharmacy Review
Post Office Box 529
Auburn, AL 36381

TOLL FREE

Fax: 1-866-606-6021

_____
Physician's Signature

_____
Date Signed