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PCSK9 Inhibitors Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004 or Provider Help Desk 1-800-454-3730

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization (PA) is required for PCSK9 Inhibitors. Payment for nonpreferred PCSK9 Inhibitors will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent, when available for the submitted diagnosis. Payment will be considered under the following conditions:

1. Patient is 18 years of age or older (or, for Homozygous Familial Hypercholesterolemia patient is 13 years of age or older)
2. Current use of a statin and documentation of adherence to prescribed lipid lowering medications for the previous 90 days is provided (further defined below, by diagnosis)
3. Is to be prescribed as an adjunct to a low fat diet
4. A baseline and current lipid profile is provided. Baseline lipid profile is defined as a lipid profile obtained prior to pharmacologic therapy
5. Documentation patient has been counseled on importance of abstinence from tobacco and, if a current smoker, be encouraged to enroll in a smoking cessation program
6. Is prescribed by a lipidologist, cardiologist or endocrinologist
7. The 72-hour emergency supply rule does not apply to PCSK9 Inhibitors

8. Prescriber and dispensing pharmacy will educate the patient on proper storage and administration. Improperly stored medications will not be replaced
9. Lost or stolen medication replacement requests will not be authorized
10. Goal is defined as a 50% reduction in untreated baseline LDL-C
11. Is prescribed for one of the following diagnoses:
    a. **Diagnosis of Heterozygous Familial Hypercholesterolemia (HeFH)**
        i. Total cholesterol > 290mg/dL or LDL-C > 190mg/dL
            1. Presence of tendon xanthomas
            2. In first or second degree relative, one of the following:
                a. Documented tendon xanthomas
                b. MI at age ≤60 years
                c. Total cholesterol > 290mg/dL
            3. Confirmation of diagnosis by gene or receptor testing (attach results)
        ii. Unable to reach goal LDL-C with a minimum of two separate, chemically distinct statin trials used in combination with other lipid lowering medications. Trials are defined as: concurrent use of a maximally tolerated dose of a statin (including atorvastatin and rosuvastatin), plus ezetimibe (Zetia) 10mg daily, PLUS cholestyramine daily.
    b. **Diagnosis of Clinical Atherosclerotic Cardiovascular Disease (ASCVD)**
        i. History of MI, angina, coronary or other arterial revascularization, stroke, TIA or PVD of atherosclerotic origin
        ii. Unable to reach goal LDL-C with a minimum of two separate, chemically distinct statin trials used in combination with other lipid lowering medications. Trials are defined as: concurrent use of a maximally tolerated dose of a statin (including atorvastatin and rosuvastatin), plus ezetimibe (Zetia) 10mg daily, plus cholestyramine daily.
    c. **Diagnosis of Homozygous Familial Hypercholesterolemia (HoFH) – Repatha (evolocumab) only**
        i. Total cholesterol and LDL-C > 600mg/dL and triglycerides within reference range
        ii. Confirmation of diagnosis by gene or receptor testing (attach results)
        iii. Unable to reach goal LDL-C with a minimum of two separate, chemically distinct statin trials used in combination with other lipid lowering medications; trials are defined as: concurrent use of a maximally tolerated dose of a statin (including atorvastatin and rosuvastatin), PLUS ezetimibe (Zetia) 10mg daily, plus cholestyramine daily

The required trials (excluding the statin trial) may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

1. Initial and Renewal Authorizations
    a. HeFH or ASCVD
        i. Initial
            1. Praluent 75mg or Repatha 140mg every 2 weeks for 8 weeks (4 doses)
        ii. Renewal
            1. Lipid profile required at week 8, week 24, and every 6 months thereafter
            2. Patient continues therapy with a maximally tolerated statin dose and remains at goal
            3. Patient has continued compliance with a low fat diet
        iii. Praluent
            1. If LDL-C at goal, continue therapy at 75mg every 2 weeks for 24 weeks
            2. If LDL-C not at goal, dose increase to 150mg every 2 weeks for 8 weeks (4 doses) and repeat LDL-C in 8 weeks
                a. If repeat LDL-C not at goal, discontinue Praluent.
                b. If repeat LDL-C at goal, continue therapy at 150mg every 2 weeks for 24 weeks.
        iv. Repatha

1. If LDL-C at goal, continue therapy at 140mg every 2 weeks for 24 weeks.
2. If LDL-C not at goal, discontinue Repatha.

v. HoFH (Repatha only)
1. Initial
    a. Repatha 420mg (3x140mg autoinjectors) every month for 3 months
2. Renewal
    a. Lipid profile required after 3 months (third dose) and every 6 months thereafter
    b. Continued therapy with a maximally tolerated statin dose
        i. If LDL-C at goal, continue therapy at 420mg every month for six months.
        ii. If LDL-C not at goal, discontinue Repatha.
    c. Patient has continued compliance with a low fat diet.

2. Quantity limits
    a. Praluent/Repatha for HeFH or ASCVD
        i. A quantity limit of 1 syringe/pen/autoinjector per fill will apply (requires refill every 14 days)
    b. Repatha for HoFH only
        i. A quantity limit of one 3-pack per month

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.