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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 1-844-474-3341.

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.)

☐ Yes ☐ No Patient has failed a 30-day treatment trial with at least 1 preferred agent(s) within the past 180 days.
☐ Yes ☐ No Patient has a documented allergy or contraindication to preferred agents in this class.
☐ Yes ☐ No Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.

For all prior authorizations:

☐ Yes ☐ No Does the client have a diagnosis of primary hyperlipidemia in the last 730 days?
☐ Yes ☐ No Does the client have a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) in the last 730 days?
☐ Yes ☐ No Does the client have a diagnosis of homozygous familiar hypercholesterolemia in the last 730 days?
☐ Yes ☐ No Does the client have a documented LDL-C of greater than (>) 130 mg/dl' to 70 mg/dl?

For renewal of prior authorizations:

☐ Yes ☐ No Has the client shown a clinical response?

For the Texas Medicaid *Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at **http://www.txvendordrug.com/formulary/formulary-search.asp**.

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

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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.
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