

PCSK9 INHIBITORS PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermy meds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

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

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

For all requests:

1. Is the patient currently treated with the requested agent? Yes No
 If yes, is the patient currently stable on the requested agent? **Please note, chart notes are required.** Yes No
2. Does the patient have any FDA labeled contraindications to the requested agent? Yes No
 If yes, please specify contraindication(s): _____
3. Is the patient’s age within FDA labeling for the requested indication for the requested agent? Yes No
 If no, is there support for using the requested agent for the patient’s age for the requested indication? Yes No
4. Will the patient be using the requested agent in combination with another PCSK9 agent for the requested indication? Yes No
5. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____

For Praluent requests, please submit chart notes to support the answers to the following questions:

6. Has the patient tried and had an inadequate response to Repatha? Yes No
7. Was Repatha discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
8. Does the patient have an intolerance or hypersensitivity to Repatha? Yes No
9. Does the patient have an FDA labeled contraindication to Repatha? Yes No
10. Is Repatha expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient’s adherence of care; OR worsen a comorbid condition; OR decrease the patient’s ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Please note, chart notes are required. Yes No

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For Praluent requests (continued), please submit chart notes to support the answers to the following questions:

11. Is Repatha not in the best interest of the patient based on medical necessity? Please note, chart notes are required. Yes No
12. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as Repatha and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Please note, chart notes are required. Yes No

Please select the patient's diagnosis (or % ASCVD risk) and answer any corresponding questions:

Clinical atherosclerotic cardiovascular disease (ASCVD)

13. Does the patient have ONE of the following: (Select all that apply.)

- acute coronary syndrome
- history of myocardial infarction
- stable or unstable angina
- coronary or other arterial revascularization
- stroke
- transient ischemic attack
- peripheral arterial disease, including aortic aneurysm, presumed to be of atherosclerotic origin
- none of the above

14. Has the patient been adherent to high-intensity statin therapy (i.e., atorvastatin 40-80mg, rosuvastatin 20-40 mg daily) for at least 8 consecutive weeks? Yes No
- If yes, does the patient's LDL-C level after this statin therapy remain greater than or equal to 70 mg/dL? Yes No
- If no, has the patient achieved a 50% reduction in LDL-C from this statin therapy? Yes No
- If yes, does the patient have ASCVD at very high risk? Yes No
- If yes, has the patient's LDL-C level after this statin therapy remained greater than or equal to 55 mg/dL? Yes No
- If no, does the patient have a hypersensitivity to atorvastatin and rosuvastatin? Yes No
- If no, does the patient have an FDA labeled contraindication to atorvastatin and rosuvastatin? Yes No
- If no, is the patient statin intolerant defined as experiencing ONE of the following: 1) Statin-related rhabdomyolysis, 2) Statin-related skeletal muscle symptoms (e.g., myopathy, myalgia), or 3) Statin-related elevated hepatic transaminase? Yes No

Heterozygous familial hypercholesterolemia (HeFH)

15. Is there genetic confirmation of one mutant allele at the LDLR, Apo-B, PCSK9, or 1/LDLRAP1 gene? Yes No
- If no, is the patient's pre-treatment LDL-C greater than 190 mg/dL? Yes No
- If no, does the patient have clinical manifestations of HeFH (e.g., cutaneous xanthomas, tendon xanthomas, corneal arcus)? Yes No
- If no, does the patient have a "definite" or "possible" familial hypercholesterolemia as defined by the Simon Broome criteria? Yes No
- If no, does the patient have a Dutch Lipid Clinic Network Criteria score of greater than 5? Yes No
- If no, does the patient have a treated LDL-C level greater than or equal to 100 mg/dL after statin treatment with or without ezetimibe? Yes No
16. Has the patient been adherent to high-intensity statin therapy (i.e., atorvastatin 40-80mg, rosuvastatin 20-40 mg daily) for at least 8 consecutive weeks? Yes No
- If yes, does the patient's LDL-C level after this statin therapy remain greater than or equal to 70 mg/dL? Yes No
- If no, has the patient achieved a 50% reduction in LDL-C from this statin therapy? Yes No
- If yes, does the patient have ASCVD at very high risk? Yes No
- If yes, has the patient's LDL-C level after this statin therapy remained greater than or equal to 55 mg/dL? Yes No
- If no, does the patient have a hypersensitivity to atorvastatin and rosuvastatin? Yes No
- If no, does the patient have an FDA labeled contraindication to atorvastatin and rosuvastatin? Yes No
- If no, is the patient statin intolerant defined as experiencing ONE of the following: 1) Statin-related rhabdomyolysis, 2) Statin-related skeletal muscle symptoms (e.g., myopathy, myalgia), or 3) Statin-related elevated hepatic transaminase? Yes No

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Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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Homozygous familial hypercholesterolemia (HoFH)

17. Is there genetic confirmation of bi-allelic pathogenic/likely pathogenic variants on different chromosomes at the LDLR, Apo-B, PCSK9, or LDLRAP1 genes, or greater than or equal to 2 such variants at different loci? Yes No
 If no, is there a history of untreated LDL-C greater than 400 mg/dL? Yes No
 If yes, does the patient have cutaneous or tendon xanthomas before age of 10 years? Yes No
 If no, does the patient have untreated elevated LDL-C levels consistent with heterozygous FH in both parents, (or in digenic form, one parent may have normal LDL-C levels and the other may have LDL-C levels consistent with HoFH)? Yes No
18. Has the patient tried a high-intensity statin (e.g., atorvastatin 40-80 mg, rosuvastatin 20-40 mg daily) for 8 weeks and had an inadequate response? Yes No
 If no, does the patient have an intolerance or hypersensitivity to ALL high-intensity statins? Yes No
 If no, does the patient have an FDA labeled contraindication to ALL high-intensity statins? Yes No

Hyperlipidemia

19. Does the patient have a coronary artery calcium (CAC) score greater than or equal to 300 Agatston units? Yes No
 If no, does the patient have a pre-treatment LDL-C level greater than or equal to 190 mg/dL? Yes No
20. Has the patient been adherent to high-intensity statin therapy (i.e., atorvastatin 40-80mg, rosuvastatin 20-40 mg daily) for at least 8 consecutive weeks? Yes No
 If yes, does the patient's LDL-C level after this statin therapy remain greater than or equal to 70 mg/dL? Yes No
 If no, has the patient achieved a 50% reduction in LDL-C from this statin therapy? Yes No
 If yes, does the patient have ASCVD at very high risk? Yes No
 If yes, has the patient's LDL-C level after this statin therapy remained greater than or equal to 55 mg/dL? Yes No
 If no, does the patient have a hypersensitivity to atorvastatin and rosuvastatin? Yes No
 If no, does the patient have an FDA labeled contraindication to atorvastatin and rosuvastatin? Yes No
 If no, is the patient statin intolerant defined as experiencing ONE of the following: 1) Statin-related rhabdomyolysis, 2) Statin-related skeletal muscle symptoms (e.g., myopathy, myalgia), or 3) Statin-related elevated hepatic transaminase? Yes No

A greater than or equal to 40% 10-year ASCVD risk

21. Does the patient have an LDL-C greater than or equal to 70 mg/dL while on maximally tolerated statin therapy? Yes No
22. Has the patient been adherent to high-intensity statin therapy (i.e., atorvastatin 40-80mg, rosuvastatin 20-40 mg daily) for at least 8 consecutive weeks? Yes No
 If yes, does the patient's LDL-C level after this statin therapy remain greater than or equal to 70 mg/dL? Yes No
 If no, has the patient achieved a 50% reduction in LDL-C from this statin therapy? Yes No
 If yes, does the patient have ASCVD at very high risk? Yes No
 If yes, has the patient's LDL-C level after this statin therapy remained greater than or equal to 55 mg/dL? Yes No
 If no, does the patient have a hypersensitivity to atorvastatin and rosuvastatin? Yes No
 If no, does the patient have an FDA labeled contraindication to atorvastatin and rosuvastatin? Yes No
 If no, is the patient statin intolerant defined as experiencing ONE of the following: 1) Statin-related rhabdomyolysis, 2) Statin-related skeletal muscle symptoms (e.g., myopathy, myalgia), or 3) Statin-related elevated hepatic transaminase? Yes No

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A 30-39% 10-year ASCVD risk

23. Does the patient have an LDL-C greater than or equal to 100 mg/dL while on maximally tolerated statin therapy? Yes No
24. Has the patient been adherent to high-intensity statin therapy (i.e., atorvastatin 40-80mg, rosuvastatin 20-40 mg daily) for at least 8 consecutive weeks? Yes No
- If yes, does the patient's LDL-C level after this statin therapy remain greater than or equal to 70 mg/dL? Yes No
- If no, has the patient achieved a 50% reduction in LDL-C from this statin therapy? Yes No
- If yes, does the patient have ASCVD at very high risk? Yes No
- If yes, has the patient's LDL-C level after this statin therapy remained greater than or equal to 55 mg/dL? Yes No
- If no, does the patient have a hypersensitivity to atorvastatin and rosuvastatin? Yes No
- If no, does the patient have an FDA labeled contraindication to atorvastatin and rosuvastatin? Yes No
- If no, is the patient statin intolerant defined as experiencing ONE of the following: 1) Statin-related rhabdomyolysis, 2) Statin-related skeletal muscle symptoms (e.g., myopathy, myalgia), or 3) Statin-related elevated hepatic transaminase? Yes No

A 20-29% 10-year ASCVD risk

25. Does the patient have an LDL-C greater than or equal to 130 mg/dL while on maximally tolerated statins? Yes No
26. Has the patient been adherent to high-intensity statin therapy (i.e., atorvastatin 40-80mg, rosuvastatin 20-40 mg daily) for at least 8 consecutive weeks? Yes No
- If yes, does the patient's LDL-C level after this statin therapy remain greater than or equal to 70 mg/dL? Yes No
- If no, has the patient achieved a 50% reduction in LDL-C from this statin therapy? Yes No
- If yes, does the patient have ASCVD at very high risk? Yes No
- If yes, has the patient's LDL-C level after this statin therapy remained greater than or equal to 55 mg/dL? Yes No
- If no, does the patient have a hypersensitivity to atorvastatin and rosuvastatin? Yes No
- If no, does the patient have an FDA labeled contraindication to atorvastatin and rosuvastatin? Yes No
- If no, is the patient statin intolerant defined as experiencing ONE of the following: 1) Statin-related rhabdomyolysis, 2) Statin-related skeletal muscle symptoms (e.g., myopathy, myalgia), or 3) Statin-related elevated hepatic transaminase? Yes No

Other (Please specify) _____

For renewal requests:

27. Has the patient had clinical benefit with a PCSK9 inhibitor? Yes No

For ASCVD, HeFH, or hyperlipidemia:

28. Has the patient been adherent to high-intensity statin therapy (i.e., atorvastatin 40-80mg, rosuvastatin 20-40 mg daily)? Yes No

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 Eagan, MN 55121

TOLL FREE

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