PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 (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 covermymeds.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. Will the patient be using the requested agent in combination with another PCSK9 agent for the requested indication? ☐ Yes ☐ No
3. Is the patient currently adherent to high-intensity statin (i.e., rosuvastatin greater than or equal to 20 mg daily, atorvastatin greater than or equal to 40 mg daily)? ☐ Yes ☐ No

If no, answer the following:

Has the patient been determined to be statin intolerant by meeting one of the following criteria:

- Has the patient experienced statin-related rhabdomyolysis? ☐ Yes ☐ No
- Has the patient experienced skeletal-related muscle symptoms (e.g., myopathy [muscle weakness] or myalgia [muscle aches, soreness, stiffness, or tenderness]) and BOTH of the following:
  - The skeletal-related muscle symptoms (e.g., myopathy or myalgia) occurred while receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination products) AND
  - When receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination products), the skeletal-related muscle symptoms (e.g., myopathy, myalgia) resolved upon discontinuation of each respective statin therapy (atorvastatin and rosuvastatin)? ☐ Yes ☐ No
- Did the patient experience elevations in hepatic transaminase while receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination products)? ☐ Yes ☐ No
- Does the patient have an FDA labeled contraindication to atorvastatin and rosuvastatin? ☐ Yes ☐ No
- Does the patient have a hypersensitivity to atorvastatin and rosuvastatin? ☐ Yes ☐ No

If yes, answer the following:

- Has the patient been adherent to high-intensity statin therapy for greater than or equal to 8 continuous weeks? ☐ Yes ☐ No
- Does the patient's LDL-C level after this treatment regimen remains greater than or equal to 70 mg/dL? ☐ Yes ☐ No
- Has the patient achieved a 50% reduction in LDL-C from baseline after this treatment regimen? ☐ Yes ☐ No
- If the patient has ASCVD, does the patient's non HDL-C level after this treatment regimen remain greater than or equal to 100 mg/dL? ☐ Yes ☐ No
- If the patient has ASCVD, is the patient at very high risk and the patient's LDL-C level after this treatment regimen remains greater than or equal to 55 mg/dL? ☐ Yes ☐ No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

4. Does the patient have any FDA labeled contraindications to the requested agent? ☐ Yes ☐ No
   If yes, please specify FDA labeled contraindications: _____
   _____
5. Was the agent prescribed by, or in consultation with, a cardiologist, an endocrinologist, and/or a physician who focuses in the treatment of cardiovascular (CV) risk management and/or lipid disorders? ☐ Yes ☐ No
6. Is the patient's age within FDA labeling for the requested indication for the requested agent? ☐ Yes ☐ No
   If no, is the patient's age within FDA labeling for the requested indication for the requested agent? ☐ Yes ☐ No
7. Is the requested quantity (dose) greater than the maximum FDA labeled dose for the requested indication? ☐ Yes ☐ No
   If no, can the requested quantity (dose) be achieved with a lower quantity of a higher strength? ☐ Yes ☐ No
   If no, please explain: _____
   _____

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

☐ **Homozygous familial hypercholesterolemia (HoFH)**

8. Has the patient had genetic confirmation of two mutant alleles at the *LDLR, Apo-B, PCSK9, or LDLRAP1* gene? ☐ Yes ☐ No
9. Does the patient have a history of untreated LDL-C greater than 500 mg/dL (greater than 13 mmol/L) or treated LDL-C greater than or equal to 300 mg/dL (greater than or equal to 7.76 mmol/L)? ☐ Yes ☐ No
10. Does the patient have clinical manifestations of HoFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas, or xanthelasma)? ☐ Yes ☐ No

☐ **Heterozygous familial hypercholesterolemia (HeFH)**

11. Has the patient had genetic confirmation of one mutant allele at the *LDLR, Apo-B, PCSK9,* or *LDLRAP1* gene? ☐ Yes ☐ No
12. Does the patient have a history of LDL-C greater than 190 mg/dL (greater than 4.9 mmol/L) (pretreatment)? ☐ Yes ☐ No
13. Does the patient have clinical manifestations of HeFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthoma, or xanthelasma)? ☐ Yes ☐ No
14. Does the patient have a Dutch Lipid Clinic Network Criteria score of greater than 5? ☐ Yes ☐ No
15. Does the patient have "definite" or "possible" familial hypercholesterolemia as defined by the Simon Broome criteria? ☐ Yes ☐ No
16. Does the patient have a treated low-density lipoprotein cholesterol (LDL-C) level greater than or equal to 100 mg/dL after treatment with antihyperlipidemic agents but prior to PCSK9 inhibitor therapy? ☐ Yes ☐ No

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

17. Does the patient have one of the following: 1) acute coronary syndrome, 2) history of myocardial infarction, 3) stable or unstable angina, 4) coronary or other arterial revascularization, 5) history of stroke, 6) history of transient ischemic attack, or 7) peripheral arterial disease, including aortic aneurysm, presumed to be of atherosclerotic origin? ☐ Yes ☐ No

☐ **Primary hyperlipidemia**

18. Does the patient have a coronary artery calcium or calcification (CAC) score greater than or equal to 300 Agatston units? ☐ Yes ☐ No
19. Does the patient have an LDL-C level greater than or equal to 220 mg/dL (greater than or equal to 5.7 mmol/L) while receiving maximally tolerated statin and ezetimibe therapy? ☐ Yes ☐ No

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

20. Does the patient have an LDL-C of greater than or equal to 70 mg/dL while on maximally tolerated statin therapy? ☐ Yes ☐ No
21. Does the patient have extensive or active burden of ASCVD (i.e., polyvascular ASCVD, which affects all 3 vascular beds-coronary, cerebrovascular, and peripheral arterial; clinical peripheral arterial disease in addition to coronary and/or cerebrovascular disease; a clinical ASCVD event with multivessel coronary artery disease defined as greater than or equal to 40% stenosis in greater than or equal to 2 large vessels; or recurrent myocardial infarction within 2 years of the initial event) in the presence of adverse or poorly controlled cardiometabolic risk factors? ☐ Yes ☐ No
22. Does the patient have extremely high-risk elevations in cardiometabolic factors with less-extensive ASCVD (i.e., diabetes, LDL-C of greater than or equal to 100 mg/dL, less than high-intensity statin therapy, chronic kidney disease, poorly controlled hypertension, high-sensitivity C-reactive protein >3 mg/L, or metabolic syndrome, usually occurring with other extremely high-risk or very-high-risk characteristics), usually with other adverse or poorly controlled cardiometabolic risk factors present? ☐ Yes ☐ No
23. Does the patient have ASCVD and LDL-C greater than or equal to 220 mg/dL with greater than or equal to 45% 10- year ASCVD risk despite statin therapy statin therapy? ☐ Yes ☐ No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

☐ **A 30-39% 10-year ASCVD risk**

24. Does the patient have LDL-C greater than or equal to 100 mg/dL while on maximally tolerated statin therapy? ☐ Yes ☐ No
25. Does the patient have less-extensive clinical ASCVD (i.e., no polyvascular ASCVD, no clinical peripheral arterial disease, a prior ASCVD event greater than or equal to 2 years prior, and no coronary artery bypass grafting)? ☐ Yes ☐ No
26. Does the patient have adverse or poorly controlled cardiometabolic risk factor(s) including age greater than or equal to 65 years, current smoking, chronic kidney disease, lipoprotein(a) greater than or equal to 37 nmol/L, high-sensitivity C-reactive protein 1-3 mg/L, metabolic syndrome with a history of myocardial infarction, ischemic stroke, or symptomatic peripheral arterial disease, usually in the presence of other adverse or poorly controlled cardiometabolic risk factors? ☐ Yes ☐ No

☐ **A 20-29% 10-year ASCVD risk**

27. Does the patient have an LDL-C of greater than or equal to 130 mg/dLwhile on maximally tolerated statins? ☐ Yes ☐ No
28. Does the patient have less extensive ASCVD and well-controlled cardiometabolic risk factors (i.e., no diabetes, nonsmoker, on high-intensity statin with LDL-C less than 100 mg/dL, blood pressure less than 140/90 mm Hg, and C-reactive protein less than 1 mg/dL)? ☐ Yes ☐ No
29. Is the use for primary prevention with LDL-C greater than or equal to 220 mg/dL? ☐ Yes ☐ No
30. Does the patient have no clinical ASCVD or CAC less than 100 Agatston units? ☐ Yes ☐ No
31. Does the patient have poorly controlled cardiometabolic risk factors? ☐ Yes ☐ No

☐ **Other (ICD code and description):**_____

For Praluent requests (chart notes are required to support the answers):

32. Has the patient tried and had an inadequate response to Repatha? ☐ Yes ☐ No
33. Was Repatha, discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
34. Does the patient have an intolerance or hypersensitivity to Repatha? ☐ Yes ☐ No
35. Does the patient have an FDA labeled contraindication to Repatha? ☐ Yes ☐ No
36. 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? ☐ Yes ☐ No
37. Is Repatha not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
38. 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? ☐ Yes ☐ No

For renewal requests:

39. Has the patient shown clinical benefit with a PCSK9? ☐ Yes ☐ No
40. Is the patient currently adherent to therapy with a PCSK9? ☐ Yes ☐ No

Please fax or mail this form to:
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Eagan, MN 55121

TOLL FREE

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