GlobalHealth

# Prior Authorization Form

# PCSK9

**This form must be completed by the prescriber or authorized personnel. INCOMPLETE FORMS WILL BE RETURNED**

## *Member Information*

**LAST NAME:** | **FIRST NAME:**

**ID NUMBER:** | **DATE OF BIRTH:** ___ – ___ – ____

## *Prescriber Information*

**LAST NAME:** | **FIRST NAME:**

**NPI NUMBER:** | **DEA NUMBER:**

**PHONE NUMBER:** ___ – ___ – ____ | **FAX NUMBER:** ___ – ___ – ____

## *Requested Medication*

☐ Praluent ☐ Repatha

Strength: _____

Quantity: _____ Directions: _____

## *Clinical Criteria Documentation*

1. **What is the primary diagnosis?** _____ **ICD Code:** _____
2. **Indicate the request type** ☐ New Start ☐ Renewal. **Date therapy was started**: _____
3. **Is the requested medication prescribed by or in consultation with a specialist related to the patient's diagnosis**? ☐ Yes ☐ No
4. **Is the patient adherent to a low-fat diet and exercise regimen**? ☐ Yes ☐ No
5. **Please list ALL medications the patient has tried and failed that relate to this request.**

Drug name: _____Strength: _____Outcome: _____ Dates tried: _____

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**5a.)** ***If member is statin intolerant due to myalgia, provide creatine kinase (CK) labs.***

6. **Has member been adherent to high-dose statin therapy for at least 8 to 12 continuous weeks**? ☐ Yes ☐ No
7. **How will this medication be used?** ❑ **Monotherapy** ❑ **Adjunct to statin therapy, diet and exercise**

Please list **ALL** medications the patient will use in combination with the requested medication for treatment of this diagnosis?

_____

_____

8. **Please provide the following labs** (*Note: Medical records are required, i.e. chart notes or labs*)

| **Pretreated:** | **Current values:** |
|---|---|
| LDL-C level: _____ mg/dL Date: _____ | LDL-C level: _____ mg/dL Date: _____ |
| Total Cholesterol: _____ g/dL Date: _____ | Total Cholesterol: _____ mg/dL Date: _____ |



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**LAST NAME:**

**FIRST NAME:**

## Additional question for Clinical atherosclerotic cardiovascular disease (ASCVD)

1. **Has the patient experienced one of the following cardiovascular events?**
   - ❑ **Acute coronary syndrome**
   - ❑ **History of myocardial infarction**
   - ❑ **Stable or unstable angina**
   - ❑ **Coronary or other arterial revascularization**
   - ❑ **Stroke**
   - ❑ **Transient ischemic attack**
   - ❑ **Peripheral arterial disease presumed to be of atherosclerotic origin**

## Additional questions for Homozygous familial hypercholesterolemia (HoFH)

1. **Does the patient have a history of prior results of genetic testing indicating an LDL-receptor mutation, familial defective apo B-100, or a PCSK9 mutation**? (*If **YES**, please attach supporting chart documentation)* ☐ Yes ☐ No
2. **Does the patient have an untreated LDL-C > 500 mg/dL and triglycerides <300mg/dL and both parents with documented untreated TC >250mg/dL**? (*If **YES**, please attach lab report*) ☐ Yes ☐ No

## Additional questions for Heterozygous familial hypercholesterolemia (HeFH)

1. **Does the patient have a history of prior results of genetic testing indicating an LDL-receptor mutation, familial defective apo B-100, or a PCSK9 mutation**? *(If **YES**, please attach supporting chart documentation)* ☐ Yes ☐ No
2. **Has diagnosis been confirmed by genotyping or by using either the Simon Broome or Dutch Lipid Network Criteria?** ☐ Yes ☐ No

   *If **YES**, please attach chart documentation.*

***Prescriber Signature (Required)*** ***Date***

*(By signature, the Physician confirms the above information is accurate and verifiable by patient records.)*

**Fax This Form to:**
**1-800-424-7573**

**Mail Requests to:**
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