Reset Form Print Form

Prior Authorization Form
Praluent® and Repatha®

Fax this form to: 1-800-424-3260

A fax cover sheet is not required.

Instructions: Please fill out all applicable sections on all pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the prior authorization). **Information contained in this form is Protected Health Information under HIPAA**.

☐ **NON-URGENT** ☐ **EXIGENT CIRCUMSTANCES**

MEMBER INFORMATION

Member's Last Name:

Member's First Name:

Member's Identification Number:

Date of Birth: – –

Member's Address:

City:

State:

ZIP:

PRESCRIBER INFORMATION

Prescriber's Last Name:

Prescriber's First Name:

National Provider Identifier (NPI) Number:

DEA Number:

Office Phone Number: – –

Office Fax Number: – –

CLINICAL CRITERIA

1. What medication is being prescribed?

   ☐ Praluent® ☐ Repatha®

2. What is the member's diagnosis? (Check all that apply.)

   ☐ Primary hyperlipidemia

   ☐ Hyperlipidemia

   ☐ Heterozygous familial hypercholesterolemia (HeFH)

   ☐ Homozygous familial hypercholesterolemia (HoFH)

   ☐ Prevention of cardiovascular events/atherosclerotic cardiovascular disease (ASCVD)

   ☐ Other (list ICD-10 code/description): _____

(Form continued on next page.)

 MHID: MRXCOM14_01

Member's Last Name:

Member's First Name:

For diagnosis of primary hyperlipidemia/heterozygous familial hypercholesterolemia (HeFH) and prevention of cardiovascular events (ASCVD):

1. Has the member's diagnosis been confirmed by genotyping?
   ☐ Yes ☐ No
2. Does the member have a first-degree relative similarly affected or with premature coronary artery disease (CAD) O with positive genetic testing for low-density lipoprotein cholesterol (LDL-C) raising gene?
   ☐ Yes ☐ No
3. Will the requested medication be used in conjunction with diet?
   ☐ Yes ☐ No
4. Will the member continue to take other low-density lipoprotein (LDL)-lowering therapies, such as statins, ezetimibe (Zetia®), or LDL apheresis?
   ☐ Yes ☐ No
5. Is the requested medication being used for primary prevention (e.g., members **without ASCVD**) and LDL-C ≥ 100 mg/dL **or** secondary prevention (e.g., members with ASCVD) and LDL-C ≥ 70 mg/dL?
   ☐ Yes ☐ No
6. What is the prescribed dosing schedule?

   _____
7. Will the requested medication be used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9)-inhibitor?
   ☐ Yes ☐ No
8. Is the member on combination therapy with a microsomal triglyceride transfer protein (MTP) inhibitor (e.g., lomitapide)?
   ☐ Yes ☐ No
9. Is the medication being prescribed by or in consultation with, a specialist in cardiology, lipidology, or endocrinology?
   ☐ Yes ☐ No
10. What is the member's current LDL-C lab value including date measured? _____
11. What is the member's treatment history involving the use of high intensity HMG-CoA reductase inhibitors (e.g., statin therapy)? Include the medication name(s), dosage(s), date(s) tried, duration of treatment(s), and results of treatment(s).

    _____
12. Is the member unable to use a maximum dose of statin therapy due to muscle symptoms and statin re-challenge has been completed?
    ☐ Yes ☐ No

(Form continued on next page.)

 MHID: MRXCOM14_01

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

13. Has the member been diagnosed with rhabdomyolysis associated with statin use by acute neuromuscular illness or dark urine?
    ☐ Yes ☐ No
    If **Yes**, provide the member's creatine kinase lab value at time of diagnosis including date labs were drawn and results:

    _____

14. Does the prescriber attest that the member has failed to reach a target LDL-C despite being adherent to maximally tolerated doses of statins prior to the lipid panel demonstrating suboptimal reduction?
    ☐ Yes ☐ No

For diagnosis of homozygous familial hypercholesterolemia (HoFH):

1. Will the requested medication be used in combination with another PCSK9-inhibitor?
   ☐ Yes ☐ No
2. Is the member on combination therapy with a microsomal triglyceride transfer protein (MTP) inhibitor (e.g., lomitapide)?
   ☐ Yes ☐ No
3. Is the medication being prescribed by, or in consultation with, a specialist in cardiology, lipidology, or endocrinology?
   ☐ Yes ☐ No
4. Has the member been receiving stable lipid-lowering therapy for at least 4 weeks?
   ☐ Yes ☐ No
5. Will the requested medication be used in conjunction with diet and other LDL-lowering therapies (e.g., statins, ezetimibe)?
   ☐ Yes ☐ No
6. Does the member have a confirmed diagnosis by any of the following? (Check all that apply.)
   ☐ Documented DNA test for function mutation(s) in LDL receptor alleles or alleles known to affect LDL receptor functionality
   ☐ Untreated LDL-C >500mg/dL or treated LDL-C ≥ 300mg/dL
   ☐ Cutaneous or tendon xanthoma before age 10 years
   ☐ Presence of untreated elevated LDL-C levels consistent with HeFH in both parents

(Form continued on next page.)

Member's Last Name:

Member's First Name:

For Renewal Requests:

1. Is the member free of any unacceptable adverse effects or toxicity that may be related to the use of the requested medication?
   ☐ Yes ☐ No
   If **No**, provide details:

   _____

2. Will the member adhere to diet and/or lipid lowering therapy established prior to the original approval?
   ☐ Yes ☐ No
3. Does the current lipid panel show a further reduction in LDL-C compared to the baseline LDL-C (documented at the initiation of therapy)?
   ☐ Yes ☐ No

_____ _____

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

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

Fax this form to: 1-800-424-3260

Mail requests to:
Magellan Rx Management Prior Authorization Program
c/o Magellan Health, Inc.
4801 E. Washington Street
Phoenix, AZ 85034
Phone: 1-800-424-3312

