carolina complete health

Pharmacy Prior Approval Request for PCSK9 Inhibitors

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. ____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (In days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

Clinical Questions for All PSCK9 Inhibitors:

1. Is the member at least 18 years of age? ☐ **Yes** ☐ **No**
2. Is the member currently taking the maximum dose, for his/her age, of atorvastatin (generic for Lipitor) or rosuvastatin (generic for Crestor) AND has completed 90 days of treatment? ☐ **Yes** ☐ **No**
3. Is the member's LDL level ≥ 70mg/dl after taking atorvastatin (generic for Lipitor) or rosuvastatin (generic for Crestor) for 90 days? ☐ **Yes** ☐ **No**
4. Does the member have a significant intolerance or allergic reaction to atorvastatin (generic for Lipitor) or rosuvastatin (generic for Crestor)? Examples of significant intolerance include severe muscle pain, significant liver abnormalities, and rhabdomyolysis. Intolerance does not include fatigue, cognitive impairment, or mild aches. ☐ **Yes** ☐ **No**
5. Has documentation of clinically significant intolerance or allergic reaction to statin treatment been attached to this prior approval request? ☐ **Yes** ☐ **No**
6. Baseline LDL before statin treatment: _____
7. LDL after statin treatment: _____

LDL lab results before and after statin treatment must be attached to this prior approval request

8. Will high dose atorvastatin (generic for Lipitor) or rosuvastatin (generic for Crestor) be continued with the PCSK9 inhibitor? ☐ **Yes** ☐ **No**

Clinical Questions for Praluent:

9. Does the member have a diagnosis of Heterozygous Familial Hypercholesterolemia? ☐ **Yes** ☐ **No**
10. Does the member have clinical atherosclerotic cardiovascular disease such as acute coronary syndromes, or a history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack, or peripheral arterial disease of atherosclerotic origin? ☐ **Yes** ☐ **No**
11. Does the member have a diagnosis of Severe Primary Hyperlipidemia (defined as LDL-C ≥ 190mg/dL)? ☐ **Yes** ☐ **No**

Clinical Questions for Repatha:

12. Does the member have a diagnosis of Heterozygous Familial Hypercholesterolemia (HeFH)? ☐ **Yes** ☐ **No**
13. Does the member have a diagnosis of Homozygous Familial Hypercholesterolemia (HoFH)? ☐ **Yes** ☐ **No**
14. Is the member 13 years or older? ☐ **Yes** ☐ **No**
15. Does the member have clinical atherosclerotic cardiovascular disease such as acute coronary syndromes, or a history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack, or peripheral arterial disease of atherosclerotic origin? ☐ **Yes** ☐ **No**
16. Does the member have a diagnosis of Severe Primary Hyperlipidemia (defined as LDL-C ≥ 190mg/dL)? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to 866-399-0929 Pharmacy PA Call Center: (833) 585-4309

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