

## 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. Ben	eficiary Gender:
Prescriber Information			
6 Prescribing Provider NPI #:			
Prescribing Provider NPI #:      Requester Contact Information - Name:			Evt
7. Requester Contact Information - Name.		FIIOHE#.	EXI
Drug Information			
8. Drug Name:	9. Strength:	10. Quantity P	er 30 Days:
11. Length of Therapy (In days): □ up to 30 D	ays □ 60 Days □ 90 Days □ 120 D	⊅ays □ 180 Days □ 365 D	ays 🗆 Other
Clinical Information			
Clinical Questions for All PSCK9 Inhibitors:			
1. Is the beneficiary currently taking the maximul	m dose, for his/her age, of atorvastatin (g	eneric for Lipitor)	
or rosuvastatin (generic for Crestor) AND has completed 90 days of treatment? ☐ Yes ☐ No			
2. Is the beneficiary's LDL level > 70mg/dl after taking atorvastatin (generic for Lipitor) or rosuvastatin (generic for			
Crestor) for 90 days? ☐ <b>Yes</b> ☐ <b>No</b>			
<ol> <li>Does the beneficiary 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</li> </ol>			
abnormalities, and rhabdomyolysis. Intolerance does not include fatigue, cognitive impairment, or mild aches.			
□ Yes □ No			
4. Has documentation of clinically significant intolerance or allergic reaction to statin treatment been attached to this			
prior approval request?   Yes   No			
5. Baseline LDL before statin treatment:			
6. LDL after statin treatment:			
**LDL lab results before and after statin treatment must be attached to this prior approval request** 7. Will high dose atorvastatin (generic for Lipitor) or rosuvastatin (generic for Crestor) be continued with the PCSK9			
inhibitor?   Yes   No			
Clinical Questions for Praluent:			
8. Is the beneficiary 18 years of age or older?	Yes □ No		
9. Does the beneficiary have a diagnosis of Hete		☐ Yes ☐ No	
10. Does the beneficiary have a diagnosis of Hom			
11. Does the beneficiary have clinical atherosclerotic cardiovascular disease such as acute coronary syndromes, or a history of			
myocardial infarction, stable or unstable angi		ation, stroke, transient ischem	iic a ttack,
or peripheral arterial disease of atherosclerot	S .		
12. Does the beneficiary have a diagnosis of Sever	, ,, ,	C <u>&gt;</u> 190mg/dL)?	1
Clinical Questions for Repatha:  13. Does the beneficiary have a diagnosis of Hete	rozygous Familial Hypercholesterolemia ()	HeFH\? ☐ Ves ☐ No	
14. Does the beneficiary have a diagnosis of Home		•	
15. Is the beneficiary 10 years or older? ☐ <b>Yes</b> ☐		,. = =	
16. Does the beneficiary have clinical atheroscler	otic cardiovascular disease such as acute	coronary syndromes, or a his	tory of
myocardial infarction, stable or unstable angi	na, coronary or other arterial revasculariz	ation, stroke, transient ischem	nic attack,
or peripheral arterial disease of atherosclerot	S .		
17. Does the beneficiary have a diagnosis of Sever		C ≥ 190mg/dL)? ☐ <b>Yes</b> ☐ <b>No</b>	
Continuation Questions for Praluent and Repath		a tharany with this =========	] Vac □ Na
<ol> <li>Has the provider submitted documentation the</li> <li>Is the beneficiary continuing to receive other</li> </ol>		o merapy with this request? L	ı tes ⊔ NO
20. Is the beneficiary currently receiving more that			
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.