PRO ACT
PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

# Praluent® Prior Authorization Request Form (Page 1 of 3)

| Patient Information (required) | | | Provider Information (required) | | |
|---|---|---|---|---|---|
| Patient Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

| Medication Information (required) | | |
|---|---|---|
| Medication Name: | Strength: | Dosage Form: |
| ❑ Check if requesting **brand** | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

## Clinical Information (required)

**Select the diagnosis below:**

❑ Atherosclerotic cardiovascular disease (ASCVD)
❑ Heterozygous familial hypercholesterolemia (HeFH)
❑ Other diagnosis:_____ICD-10 Code(s): _____

**Clinical Information:**

Select if the patient has heterozygous familial hypercholesterolemia (HeFH) as confirmed by the following:*
- ❑ Documented assessment of patient using Dutch Lipid Clinic Network diagnostic criteria with a cumulative score greater than or equal to 9 points (i.e., definite FH)
- ❑ Presence of tendinous xanthomas in patient, first degree relative, or second degree rel ative
- ❑ Untreated/pre-treatment LDL-cholesterol (LDL-C) > 190 mg/dL in an adult or > 155 mg/dL in a child less than 16 years of age
- ❑ Genetic confirmation of a mutation in the LDL receptor, ApoB, or PCSK9

Select if the patient has atherosclerotic cardiovascular disease (ASCVD) confirmed by the following:*
- ❑ Acute coronary syndromes
- ❑ History of myocardial infarction
- ❑ Stable or unstable angina
- ❑ Coronary or arterial revascularization
- ❑ Stroke
- ❑ Transient ischemic attack
- ❑ Peripheral arterial disease presumed to be of atherosclerotic origin

**Please note: Chart documentation of the above is required to be submitted along with this fax.*

Has the patient been receiving at least 12 consecutive weeks of ezetimibe? ❑ **Yes** ❑ **No**
If "yes", will the patient continue to receive ezetimibe as adjunct to maximally tolerated statin therapy? ❑ **Yes** ❑ **No**
If "no", does the patient have history of **contraindication or intolerance** to ezetimibe? ❑ **Yes** ❑ **No**

Has the patient been receiving at least 12 consecutive weeks of a bile acid sequestrant [e.g., Welchol (colesevelam), cholestyramine]? ❑ **Yes** ❑ **No**
If "yes", will the patient continue to receive a bile acid sequestrant as adjunct to maximally tolerated statin therapy? ❑ **Yes** ❑ **No**
If "no", does the patient have history of **contraindication or intolerance** to a bile acid sequestrant? ❑ **Yes** ❑ **No**

Select if the patient has one of the following LDL-C values while on a maximally tolerated lipid-lowering regimens ***within the last 30 days***:
- ❑ LDL-C ≥100 mg/dL with ASCVD
- ❑ LDL-C ≥130 mg/dL without ASCVD

Will Praluent be used as adjunct to a low-fat diet and exercise regimen? ❑ **Yes** ❑ **No**

Select the prescriber's specialty:
- ❑ Cardiologist
- ❑ Endocrinologist
- ❑ Lipid specialist

Will Praluent be used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor? ❑ **Yes** ❑ **No**

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Has the patient been receiving at least 12 consecutive weeks of **high-intensity** statin therapy [i.e., atorvastatin 40-80 mg, Crestor (rosuvastatin) 20-40 mg] at a maximally tolerated dose? ❑ **Yes** ❑ **No**

Will the patient continue to receive a **high-intensity** statin medication? ❑ **Yes** ❑ **No**

Select if the patient is unable to tolerate **high-intensity** statin therapy as evidenced by one of the following intolerable and persistent (i.e., more than 2 weeks) symptoms:

❑ Myalgia (muscle symptoms without CK elevations)
❑ Myositis (muscle symptoms with CK elevations < 10 times upper limit of normal [ULN])

Has the patient been receiving at least 12 consecutive weeks of **moderate-intensity** statin therapy [i.e., atorvastatin **10-20** mg, Crestor (rosuvastatin) 5-10 mg, simvastatin 20-40 mg, pravastatin 40-80 mg, lovastatin 40 mg, Lescol XL (fluvastatin XL) 80 mg, fluvastatin 40 mg twice daily, or Livalo (pitavastatin) 2-4 mg] at a maximally tolerated dose? ❑ **Yes** ❑ **No**

Will the patient continue to receive a **moderate-intensity** statin medication? ❑ **Yes** ❑ **No**

Select if the patient is unable to tolerate **moderate-intensity** or high-intensity statin therapy as evidenced by one of the following intolerable and persistent (i.e., more than 2 weeks) symptoms:

❑ Myalgia (muscle symptoms without CK elevations)
❑ Myositis (muscle symptoms with CK elevations < 10 times upper limit of normal [ULN])

Has the patient been receiving at least 12 consecutive weeks of **low-intensity** statin therapy [i.e., simvastatin 10 mg, pravastatin 10-20mg, lovastatin 20mg, fluvastatin 20-40mg, Livalo (pitavastatin) 1 mg] at a maximally tolerated dose? ❑ **Yes** ❑ **No**

Will the patient continue to receive a **low-intensity** statin medication? ❑ **Yes** ❑ **No**

Select if the patient is unable to tolerate **low-**, **moderate-**, and **high-intensity** statin therapy as evidenced by one of the following intolerable and persistent (i.e., more than 2 weeks) symptoms:

❑ Myalgia (muscle symptoms without CK elevations)
❑ Myositis (muscle symptoms with CK elevations < 10 times upper limit of normal [ULN])

Has the patient undergone a trial of statin rechallenge with pravastatin 10-40mg or rosuvastatin 5mg with documented reappearance of muscle symptoms? ❑ **Yes** ❑ **No**

Does the patient have a labeled contraindication to all statins as documented in medical records? * ❑ **Yes** ❑ **No**
**Please note: Chart documentation of the above is required to be submitted along with this fax.*

Has the patient experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations > 10 times upper limit of normal? ❑ **Yes** ❑ **No**

**Reauthorization:**

**If this is a reauthorization request, answer the following questions:**

Does the patient continue to receive statin therapy at a maximally tolerated dose (unless patient has documented inability to take statins)? ❑ **Yes** ❑ **No**

Does the patient continue to receive ezetimibe as an adjunct to maximally tolerated statin therapy (unless patient has docume nted inability to take ezetimibe)? ❑ **Yes** ❑ **No**

Does the patient continue to receive bile acid sequestrant therapy as an adjunct to maximally tolerated statin therapy (unless patient has documented inability to take bile acid sequestrant therapy)? ❑ **Yes** ❑ **No**

Has the patient been adherent to Praluent therapy? ❑ **Yes** ❑ **No**

Is the patient continuing a low-fat diet and exercise regimen? ❑ **Yes** ❑ **No**

Select the prescriber's specialty:

❑ Cardiologist ❑ Endocrinologist ❑ Lipid specialist

Will medical records (e.g., laboratory values) be submitted documenting the patient has sustained > 30% reduction in LDL-C levels from pretreatment baseline (i.e., prior to PCSK9 therapy) while on PCSK9 therapy?* ❑ **Yes** ❑ **No**
**Please note: Chart documentation of the above is required to be submitted along with this fax.*

Will Praluent be used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor? ❑ **Yes** ❑ **No**

**Quantity Limit Requests:**

What is the quantity requested per MONTH? _____

**What is the reason for exceeding the plan limitations?**

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

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**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

Please note: This request may be denied unless all required information is received.

**Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.**

**Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.**

**I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.**

**Provider/Representative (and Title):** _____ **Date:** _____

| **PROACT INTERNAL USE ONLY:** | | | | | |
|---|---|---|---|---|---|
| **Clinical Review Decision** | | | | | |
| | **Approved, through** | | | | |
| | **Denied (documentation attached, if necessary)** | | | | |
| **Tracking:** | | | | | |
| 1st Attempt | | 2nd Attempt | | Letter Mailed: | |