PRO ACT
PHARMACY BENEFIT MANAGEMENT

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

Repatha® Prior Authorization Request Form (Page 1 of 3)

Patient Information (required)

Patient Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
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:

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

Clinical Information:

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, 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 low-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])

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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**

Has the patient been receiving at least 12 weeks 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 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 regimen ***within the last 30 days***:
❑ LDL-C ≥100 mg/dL with ASCVD
❑ LDL-C ≥130 mg/dL without ASCVD

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

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

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

For primary hyperlipidemia (HeFH and/or ASCVD), also answer the following:

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 relative
❑ 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.*

Does the patient have history of **failure** after 12 consecutive weeks of Praluent 150mg therapy? ❑ **Yes** ❑ **No**

Does the patient have history of **intolerance** to Praluent therapy? ❑ **Yes** ❑ **No**

For homozygous familial hypercholesterolemia (HoFH), also answer the following:

Select if the patient has homozygous familial hypercholesterolemia (HoFH) as confirmed by the following:*
❑ Genetic confirmation of 2 mutations in the LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1 (i.e., LDLRAP1 or ARH)
❑ Untreated/pre-treatment LDL-cholesterol (LDL-C) > 500 mg/dL or treated LDL-C > 300 mg/dL
❑ Xanthoma before 10 years of age
❑ Evidence of heterozygous familial hypercholesterolemia in both parents

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

Will Repatha be used in combination with Juxtapid (lomitapide)? ❑ **Yes** ❑ **No**

Will Repatha be used in combination with Kynamro (mipomersen)? ❑ **Yes** ❑ **No**

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Reauthorization:

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

Does the patient continue to receive a statin at the 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 documented 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 Repatha 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 Repatha be used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor? ❑ **Yes** ❑ **No**

For homozygous familial hypercholesterolemia (HoFH), also answer the following:

Will Repatha be used in combination with Juxtapid (lomitapide)? ❑ **Yes** ❑ **No**

Will Repatha be used in combination with Kynamro (mipomersen)? ❑ **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: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician fe els 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.

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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:	