Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

Prior Authorization (PA) Form

PROPROTEIN CONVERTASE SUBTILISIN KEXIN TYPE 9 (PCSK9)

If the following information is not complete, correct, or legible, the PA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name:

First Name:

Medicaid ID Number:

Date of Birth: ___ – ___ – ____

Gender: ☐ **Male** ☐ **Female**

Is Member Over 18 Years of Age? ☐ **Yes** ☐ **No**

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number: ___ – ___ – ____

Fax Number: ___ – ___ – ____

Specialty: Is the drug prescribed by or in consultation with a specialist?

☐ Cardiologists ☐ Lipidologists ☐ Endocrinologists ☐ Other: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

AVAPEC-2306-19 December 2019

PROPROTEIN CONVERTASE SUBTILISIN KEXIN TYPE 9 (PCSK9)

Member's Last Name:

Member's First Name:

CRITERIA

1. Indications the drug is being prescribed for?
   - ☐ Homozygous familial hypercholesterolemia (HoFH)
   - ☐ Heterozygous familial hypercholesterolemia (HeFH)
   - ☐ Clinical atherosclerotic cardiovascular disease (ASCVD) or history of a cardiovascular event without homozygous/heterozygous familial hypercholesterolemia
   - ☐ Other
2. Has the member been able to achieve target LDL-C levels using other lipid-lowering interventions?
   ☐ Yes ☐ No
3. Has the member had prior treatment history with highest available dose or maximally-tolerated dose of high intensity statin (atorvastatin or rosuvastatin) AND ezetimibe for at least three continuous months with failure to reach target LDL-C **and** is in one of the 3 groups identified by NLA; extremely high risk ASCVD members with LDL-C ≥ 70 mg/dL, very high risk ASCVD members with LDL-C ≥ 100 mg/dL, and high risk members with LDL-C ≥ 130 mg/dL.
   ☐ Yes ☐ No
4. Is this request for a new start or continuation of Praluent/Repatha therapy?
   ☐ Yes ☐ No
   a. If New start, skip to diagnosis section ☐ New Start ☐ Continuation
5. Was Praluent/Repatha previously authorized for this member and they are stable on the medication? If No, skip to diagnosis section.
   ☐ Yes ☐ No
6. How long has the member been receiving treatment with Praluent/Repatha?
   a. 3 to 5 months (or first renewal request after initial authorization ☐
   b. 6 months or more (or second and subsequent renewal requests) ☐
7. Has the member achieved an at least 30% reduction in LDL-C since the beginning of treatment with Praluent/Repatha? **ACTION REQUIRED: If Yes, please attach clinical notes and laboratory results that support an at least 30% reduction in LDL-C after initiation of Praluent/Repatha therapy.**
   ☐ Yes ☐ No
8. Does the member continue to receive benefit from Praluent/Repatha treatment as measured by either of the following: 1) continued decrease in LDL-C levels, or 2) maintenance of optimum LDL-C levels? **ACTION REQUIRED: If yes, please attach clinical notes and laboratory results that support continued benefit of Praluent/Repatha therapy.**
   ☐ Yes ☐ No

(Form continued on next page.)

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

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

9. The member is not able to use a maximum dose of atorvastatin or rosuvastatin due to muscle symptoms, documentation of a causal relationship must be established between statin use and muscle symptoms. Documentation must demonstrate that the member experienced pain, tenderness, stiffness, cramping, weakness, and/or fatigue and all of the following:
   a. Muscle symptoms resolved after discontinuation of statin; AND
   b. Muscle symptoms occurred when re-challenged at a lower dose of the same statin; AND
   c. Muscle symptoms occurred after switching to an alternative statin; AND
   d. Documentation ruling out non-statin causes of muscle symptoms (e.g., hypothyroidism, reduced renal function, reduced hepatic function, rheumatologic disorders, such as polymyalgia rheumatica, steroid myopathy, vitamin D deficiency, or primary muscle disease); OR
   e. The member has been diagnosed with statin-induced rhabdomyolysis

   ☐ Yes ☐ No

   If yes to any, give details: _____

DIAGNOSIS AND LAB VALUES FOR HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA(HOFH)

10. Has genetic testing confirmed the presence of 2 mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus? **ACTION REQUIRED: If yes, please attach a copy of genetic testing result.**

    ☐ Yes ☐ No

11. Has the diagnosis of HoFH been confirmed by ANY of the following? **ACTION REQUIRED: Please indicate below and provide a copy of the laboratory report with LDL-C level at time of diagnosis and other documentation supporting the presence of xanthoma or family history of HoFH (e.g., chart notes, medical records).**

    ☐ Untreated LDL-C > 500 mg/dL AND cutaneous or tendon xanthoma before age 10 years
    ☐ Untreated LDL-C > 500 mg/dL AND untreated elevated LDL-C levels consistent with heterozygous familial hypercholesterolemia in both parents
    ☐ Treated LDL-C ≥ 300 mg/dL AND cutaneous or tendon xanthoma before age 10 years
    ☐ Treated LDL-C ≥ 300 mg/dL AND untreated elevated LDL-C levels consistent with heterozygous familial hypercholesterolemia in both parents
    ☐ No/none of the above

(Form continued on next page.)

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

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

12. Does the member have a history of clinical atherosclerotic cardiovascular disease (ASCVD) or a cardiovascular event listed below?
    - ☐ Yes ☐ No
    - ☐ Acute coronary syndromes ☐ Myocardial infarction ☐ Stable or unstable angina
    - ☐ Stroke of presumed atherosclerotic origin ☐ Transient ischemic attack (TIA)
    - ☐ Coronary or other arterial revascularization procedure (e.g., PTCA, CABG)
    - ☐ Peripheral arterial disease of presumed atherosclerotic origin
    - ☐ Findings from CT angiogram or catheterization consistent with clinical ASCVD

13. What is the member's pre-treatment LDL-C level (i.e., prior to starting PCSK9 inhibitor therapy)? _____ mg/dL.

14. Is age ≥ 13 years if diagnosed with homozygous familial hypercholesterolemia (HoFH)?
    - ☐ Yes ☐ No

DIAGNOSIS AND LAB VALUES FOR HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA(HEFH)

15. Does the member have a **definite** diagnosis of heterozygous familial hypercholesterolemia (HeFH) as defined by the Dutch Lipid Clinic Network criteria (total score greater than 8)? **ACTION REQUIRED: If yes, please provide a copy of the lab repot with LDL-C level at time of diagnosis and other documentation supporting clinical/family history and/or physical findings (e.g., chart notes, medical records).**
    - ☐ Yes ☐ No

16. Does the member have a definite diagnosis of HeFH as defined by Simon Broome diagnostic criteria?
    - ☐ Yes ☐ No

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.

The completed form may be **FAXED TO 1-844-512-7020**.