AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – 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. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other:_____

Clinical Information

Clinical Questions for All PCSK9 Inhibitors:

1. Is the beneficiary 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___
2. Is the beneficiary's LDL level ≥ 70mg/dl after taking atorvastatin (generic for Lipitor) or rosuvastatin (generic for Crestor) for 90 days? Yes___ No___
3. 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 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 Heterozygous Familial Hypercholesterolemia? Yes___ No___
10. Does the beneficiary have a diagnosis of Homozygous Familial Hypercholesterolemia? Yes___ No___
11. Does the beneficiary have a 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___
12. Does the beneficiary have a diagnosis of Severe Primary Hyperlipidemia (defined as LDL-C ≥ 190mg/dL)? Yes___ No___

Clinical Questions for Repatha:

13. Does the beneficiary have a diagnosis of Heterozygous Familial Hypercholesterolemia (HeFH)? Yes___ No___
14. Does the beneficiary have a diagnosis of Homozygous Familial Hypercholesterolemia (HoFH)? Yes___ No___
15. Is the beneficiary 10 years or older? Yes___ No___
16. Does the beneficiary 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___
17. Does the beneficiary have a diagnosis of Severe Primary Hyperlipidemia (defined as LDL-C ≥ 190mg/dL)? Yes___ No___

Continuation Questions for Praluent and Repatha:

18. Has the provider submitted documentation that indicates a positive clinical response to therapy with this request? Yes___ No___
19. Is the beneficiary continuing to receive other lipid-lowering therapy? Yes___ No___
20. Is the beneficiary currently receiving more than one PCSK9 inhibitor? 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: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406