# PRIOR AUTHORIZATION REQUEST FORM

**EOC ID:**

# Repatha

**Phone: 800-728-7947 Fax back to: 866-880-4532**

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

| **Patient Name:** | **Prescriber Name:**<br>**Supervising Physician:** | |
|---|---|---|
| Member/Subscriber Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| Group Number: | NPI: | State Lic ID: |
| Address: | Address: | |
| City, State ZIP: | City, State ZIP: | |
| Primary Phone: | Specialty/facility name (if applicable): | |

Drug Name and Strength:

Directions / SIG:

**Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.**

Q1. Which type of request is this?

☐ Initial ☐ Renewal (i.e. renewal of 140 mg dose OR renewal for 420 mg dose)

Q2. Select the regimen that is being requested.

☐ Repatha 140 mg every 2 weeks (2 injections per 28 days) ☐ Repatha 420 mg every 4 weeks (Pushtronex cartridge every 28 days)

Q3. Please provide most recent chart note, labs, genotype testing, and any additional documentation that may be beneficial to pharmacist and medical director during the prior authorization case review. Coverage will not be approved without documentation to confirm the patient meets all criteria.

Q4. Specify the prescriber's specialty

☐ Cardiologist
☐ Endocrinologist
☐ Board Certified Lipidologist
☐ Other

Q5. Which diagnosis is the drug being prescribed for (select ALL that apply)?

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☐ Heterozygous Familial hypercholesterolemia (HeFH)
☐ Homozygous Familial hypercholesterolemia (HoFH)
☐ Clinical ASCVD with history of myocardial infarction (MI)
☐ Clinical ASCVD with history of acute coronary syndrome (ACS)
☐ Clinical ASCVD with history of stable or unstable angina
☐ Clinical ASCVD with history of thromboembolic stroke
☐ Clinical ASCVD with history of transient ischemic attack (TIA)
☐ Clinical ASCVD with history of peripheral artery disease (PAD)
☐ Clinical ASCVD with history of coronary or other arterial revascularization
☐ Other (specify)

Q6. Was diagnosis of familial hypercholesterolemia (FH) confirmed by GENETIC TESTING?

☐ Yes
☐ No
☐ NA - Patient does not have FH

Q7. Was diagnosis of FH confirmed by MedPed/WHO score GREATER THAN OR EQUAL TO 6 per 2011 ESC/EAS guidelines (refer to question 9)

☐ Yes - provide total score
☐ No
☐ NA - Patient does not have FH

Q8. MedPed/WHO Heterozygous Familial Hypercholesterolemia Clinical Diagnostic Criteria (please select all that apply):

☐ First-degree relative known with premature CAD and/or first-degree relative with LDL-C greater than 95th percentile (1 point)
☐ First-degree relative with tendon xanthomata and/or children under 18 with LDL-C greater than 95th percentile (2 points)
☐ Patient has premature CAD (male younger than 55 year; female younger than 60 years) (2 points)
☐ Patient has premature cerebral/peripheral vascular disease (1 point)
☐ Tendon xanthomata (6 points)
☐ Arcus cornealis below the age of 45 years (4 points)
☐ LDL-C greater than 330 mg/dL (8 points)
☐ LDL-C 250 – 329 mg/dL (5 points)
☐ LDL-C 190 – 249 mg/dL (3 points)
☐ LDL-C 155 – 189 mg/dL (1 point)

Q9. Which of the following applies to the patient?

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☐ LDL GREATER THAN OR EQUAL TO 160 mg/dL despite ADHERENCE to MAXIMIZED lipid lowering therapy
☐ LDL GREATER THAN OR EQUAL TO 160 mg/dL but patient is NOT ADHERENT to MAXIMIZED lipid lowering therapy
☐ LDL GREATER THAN OR EQUAL TO 130 mg/dL despite ADHERENCE to MAXIMIZED lipid lowering therapy
☐ LDL GREATER THAN OR EQUAL TO 130 mg/dL but patient is NOT ADHERENT to MAXIMIZED lipid lowering therapy
☐ LDL BELOW 130 mg/dL

Q10. Does the patient have DOCUMENTED ADHERENCE to 2013 AHA/ACC Lifestyle Management Guidelines (e.g. heart healthy diet, aerobic exercise 3-4 times a week, active weight loss if BMI above 25 kg/m2)?

☐ Yes ☐ No

Q11. Does the patient smoke?

☐ Yes ☐ No

Q12. Select ALL statements that apply to this patient.

☐ Failure to reach LDL goal concentration despite at least 80% ADHERENCE to a 90 DAY TRIAL of ATORVASTATIN 80 mg daily in combination with ZETIA
☐ Failure to reach LDL goal concentration despite at least 80% ADHERENCE to a 90 DAY TRIAL of ROSUVASTATIN 40 mg daily in combination with ZETIA
☐ None of the above apply to this patient

Q13. Does the patient have any of the following contraindications to HMG-CoA reductase inhibitors (select ALL that apply to the patient)?

☐ Immune-mediated hypersensitivity
☐ Active liver disease (Does NOT include: chronic, stable liver disease such as hepatitis B, hepatitis C or non-alcoholic fatty liver)
☐ Laboratory-confirmed acute liver injury secondary to HMG-CoA reductase inhibitor therapy
☐ Laboratory-confirmed rhabdomyolysis secondary to HMG-CoA reductase inhibitor therapy
☐ None of the above

Q14. Select ALL of the following intolerances to HMG-CoA reductase inhibitor therapy that apply to this patient.

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- ☐ Intolerable, persistent, bilateral myalgia (muscle symptoms withOUT creatine kinase elevations)
- ☐ Myopathy (muscle weakness with creatine kinase elevations greater than 3 times baseline or ULN)
- ☐ Myositis (creatine kinase elevations greater than 3 times baseline or ULN withOUT muscle symptoms)
- ☐ None of the above

Q15. If the patient experienced intolerance to HMG-CoA reductase inhibitor therapy, specify the agent(s) that the patient was intolerant to (include drug, strength, regimen, duration).

Q16. If the patient experienced an intolerance to HMG-CoA reductase therapy, did the patient have symptom improvement upon HMG-CoA reductase inhibitor dose decrease or discontinuation?

- ☐ Yes
- ☐ No
- ☐ NA - Patient did not experience intolerance

Q17. If the patient experienced intolerance to HMG-CoA reductase inhibitor therapy, were the symptoms attributable to another cause such as drug interactions or recognized modifiable conditions that increase risk of statin intolerance?

- ☐ Yes
- ☐ No
- ☐ NA - Patient did not experience intolerance

Q18. If the patient experienced intolerance to HMG-CoA reductase therapy, select ALL of the following that patient experienced intolerance.

- ☐ Atorvastatin 10 mg
- ☐ Fluvastatin 20 mg
- ☐ Lovastatin 20 mg
- ☐ Pravastatin 10 mg
- ☐ Rosuvastatin 5 mg
- ☐ Simvastatin 10 mg
- ☐ NA - patient did not experience intolerance

Q19. When taking Repatha, will the member continue the highest tolerated dose of HMG-CoA reductase inhibitor therapy AND other lipid lowering therapies?

☐ Yes ☐ No

Q20. Specify the HMG-CoA reductase inhibitor AND other lipid lowering therapies the patient will be taking with

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Repatha(include drug, strength, and directions for each agent).

Q21. Provide patient's BASELINE LDL (prior to initiation of ANY lipid therapies) and DATE it was measured.

Q22. Provide the TARGET LDL level for this patient.

Q23. Provide a recent LDL level for the patient taken within the PAST 30 DAYS and DATE it was measured.

Q24. If requesting CONTINUATION, provide the patient's PRE-REPATHA LDL and DATE it was measured.

Q25. Specify DATE patient received FIRST DOSE of Repatha therapy.

Q26. If requesting CONTINUATION, select ALL of the following that apply to this patient:

- ☐ Documentation of ADHERENCE to Repatha therapy (verified by claims history)
- ☐ Documentation of ADHERENCE to concomitant lipid lowering therapies (verified by claims history)
- ☐ Documentation of ADHERENCE to the 2013 AHA/ACC Lifestyle Management Guidelines (e.g. heart healthy diet, aerobic exercise 3-4 times a week, active weight loss if BMI greater than 25 kg/m2)
- ☐ Nonsmoker
- ☐ None of the above apply to this patient

Q27. For CONTINUATION, select ALL of the following that apply to this patient.

- ☐ GREATER THAN 50% reduction in baseline (non-treated LDL)
- ☐ Reaching pre-specified goal LDL concentration
- ☐ GREATER THAN OR EQUAL TO 35% reduction in LDL concentration since starting Repatha.

Q28. Additional Comments

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Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.