PRIOR AUTHORIZATION REQUEST FORM

Medicare Part D 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:** **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 select the prescriber's specialty.

- ☐ Cardiologist
- ☐ Endocrinologist
- ☐ Board Certified Lipidologist
- ☐ Other (Please Specify)

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Q4. Please provide most recent chart note, relevant labs including baseline LDL and current LDL, genetic testing, medical documentation confirming diagnosis, complete lipid treatment history, and any additional documentation that may be beneficial to pharmacist and medical director during the prior authorization case review.

Q5. Select ALL of the following that apply to this patient:

- ☐ Patient currently on a high-intensity statin and has been on current regimen for at least 3 months. High-intensity statin defined as atorvastatin 40 - 80 mg or rosuvastatin 20 - 40 mg.
- ☐ Documentation of FDA labeled contraindication to statin therapy (Please specify and answer question 6)
- ☐ Documentation of statin intolerance to lowest average starting dose of ALL formulary statins, defined as intolerable bilateral muscle side effects or biomarker changes (elevations in CK) that decrease after discontinuation of therapy. (Please specify and answer question 7)

Q6. If patient has an FDA labeled contraindication to statin therapy please select all of the following that apply:

- ☐ 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

Q7. Select ALL of the following formulary statin medications that patient has tried.

- ☐ Atorvastatin 10 mg
- ☐ Lovastatin 20 mg
- ☐ Pravastatin 10 mg
- ☐ Rosuvastatin 5 mg
- ☐ Simvastatin 10 mg
- ☐ None

Q8. For treatment of familial hypercholesterolemia (FH), select all of the following diagnostic criteria that apply to patient. (Please submit all supporting documentation with request)

- ☐ Documentation of genetic mutation in one of the following genes: LDLR, APOB, or PCSK9
- ☐ Documentation of WHO MedPed Score of 6 or higher (see question 11)

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☐ Documentation of LDL-C greater than 330 mg/dL

☐ Documentation of LDL-C greater than 190 mg/dL AND presence of tendon xanthomas in patient or in first- or second-degree relative

☐ Documentation of LDL-C greater than 190 mg/dL AND history of premature atherosclerotic cardiovascular disease (ASCVD) in men less than 55 years or women less than 60 years

☐ Documentation of LDL-C greater than 190 mg/dL AND first-degree relative with premature ASCVD (men less than 55 years and women less than 60 years)

Q9. For treatment of atherosclerotic cardiovascular disease (ASCVD), does member have a LDL-C level of greater than or equal to 70 mg/dL despite 3 months of continuous statin therapy?

☐ Yes ☐ No

Q10. For treatment of atherosclerotic cardiovascular disease (ASCVD), please select all of the following that apply to patient:

☐ NSTEMI
☐ Myocardial infarction (MI)
☐ Unstable angina
☐ Coronary revascularization
☐ Clinically significant multi-vessel coronary heart disease
☐ None of the above

Q11. 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)

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☐ LDL-C 190 – 249 mg/dL (3 points)
☐ LDL-C 155 – 189 mg/dL (1 point)

Q12. For continuation of therapy, please select all of the following that apply to patient:

☐ >50% reduction in baseline (non-treated) LDL
☐ Reaching prespecified goal LDL concentration
☐ >35% reduction in LDL concentration since starting Repatha
☐ None of the above

Q13. Additional Comments

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