PRIOR AUTHORIZATION REQUEST FORM

Medicare Part D Kynamro

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. For what diagnosis is the drug being prescribed (pick one)?

☐ Homozygous Familial Hypercholesterolemia (HoFH)
☐ Other

Q2. Please provide ICD code(s) for diagnosis

Q3. Has patient failed an adequate trial (30 days) of high-dose statin therapy? (High-dose therapy: atorvastatin 40-80 mg or rosuvastatin 20-40 mg)

☐ Yes ☐ No

Q4. If patient has not failed an adequate trial of high-dose statin therapy, does patient have a contraindication or intolerance to high-dose statin therapy? (High-dose therapy: atorvastatin 40-80 mg or rosuvastatin 20-40 mg) [Please describe treatment history]

☐ Yes ☐ No

Q5. 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