PRIOR AUTHORIZATION REQUEST
Praluent

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. ☐ Yes ☐ No Is the requested medication being used concurrently with Repatha or Juxtapid?
2. ☐ Yes ☐ No Is the requested medication being prescribed by, or in consultation with, a cardiologist; an endocrinologist; or a physician who focuses in the treatment of cardiovascular (CV) risk management and/or lipid disorders?
3. What is the indication or diagnosis?
   - ☐ Atherosclerotic cardiovascular disease (ASCVD) [clinical] – **Please answer questions 12 - 21 & 27**
   - ☐ Heterozygous familial hypercholesterolemia (HeFH) - **Please answer questions 4 - 11 & 17 - 21, 27**
   - ☐ Primary Hyperlipidemia [please review under those other indications if present] - **Please answer questions 19 & 21 - 27**
   - ☐ All other indications or diagnoses – Please specify _____
4. ☐ Yes ☐ No Does the patient have an untreated low-density lipoprotein cholesterol (LDL-C) level is greater than or equal to 190 mg/dL (that is, prior to treatment with antihyperlipidemic agents)?
5. ☐ Yes ☐ No Does the patient have genetic confirmation of HeFH by mutations in the low-density lipoprotein receptor (LDLR), apolipoprotein B (APOB), proprotein convertase subtilisin kexin type 9 (PCSK9) or low-density lipoprotein receptor adaptor protein 1 (LDLRAP1) gene?
6. ☐ Yes ☐ No Has the patient been diagnosed with HeFH by the prescriber using the Dutch Lipid Network criteria?
7. ☐ Yes ☐ No Does the patient have a score of greater than 5?
8. ☐ Yes ☐ No Has the patient been diagnosed with HeFH by the prescriber using the Simon Broome criteria?
9. ☐ Yes ☐ No Has the patient met the threshold for "definite" or "possible" familial hypercholesterolemia?

If you have any questions, call: 800-753-2851

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10. □ Yes □ No Does the patient have clinical manifestations of HeFH?
11. □ Yes □ No Does the patient have a treated low-density lipoprotein cholesterol (LDL-C) level greater than or equal to 100 mg/dL (that is, after treatment with antihyperlipidemic agents but prior to treatment with PCSK9 inhibitor therapy (such as Praluent or Repatha)?
12. □ Yes □ No Has the patient had a previous myocardial infarction (MI) or history of an acute coronary syndrome (ACS)?
13. □ Yes □ No Does the patient have a diagnosis of angina (stable or unstable)?
14. □ Yes □ No Does the patient have a past history of stroke or transient ischemic attack (TIA)?
15. □ Yes □ No Does the patient have peripheral arterial disease (PAD)?
16. □ Yes □ No Has the patient undergone a coronary or other arterial revascularization procedure in the past?
17. □ Yes □ No Has the patient tried one high-intensity statin therapy (that is, atorvastatin 40 mg or greater daily; rosuvastatin 20 mg or greater daily [as a single-entity or as a combination product]) for at least 8 weeks continuously?
18. □ Yes □ No Does the patient's low-density lipoprotein cholesterol (LDL-C) level after this treatment remain greater than or equal to 70 mg/dL?
19. □ Yes □ No Has the patient been determined to be statin intolerant by experiencing statin-related rhabdomyolysis?
20. □ Yes □ No Has the patient been determined to be statin intolerant by experiencing skeletal-related muscle symptoms?
21. □ Yes □ No Did the skeletal-related muscle symptoms occur while receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination products)?
22. □ Yes □ No Is the patient's coronary artery calcium or calcification (CAC) score greater than or equal to 300 Agatston units?
23. □ Yes □ No Has the patient tried one high-intensity statin therapy (that is, atorvastatin 40 mg or greater daily; rosuvastatin 20 mg or greater daily [as a single-entity or as a combination product])?
24. □ Yes □ No Was the high-intensity statin therapy (that is, atorvastatin 40 mg or greater daily; rosuvastatin 20 mg or greater daily [as a single-entity or as a combination product]) given with ezetimibe (as a single-entity or as a combination product) for at least 8 weeks continuously?
25. □ Yes □ No Does the patient's low-density lipoprotein cholesterol (LDL-C) level after this treatment regimen remain greater than or equal to 100 mg/dL?
26. □ Yes □ No Has the patient been determined to be statin intolerant by experiencing skeletal-related muscle symptoms?
27. □ Yes □ No When receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination products) did the skeletal-related muscle symptoms resolve upon discontinuation of each respective statin therapy (atorvastatin AND rosuvastatin)?

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Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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