



**Praluent (Alirocumab)
Prior Authorization Request Form**



Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

URGENT

MEMBER INFORMATION		
LAST NAME:	FIRST NAME:	
PHONE NUMBER:	DATE OF BIRTH:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
PATIENT INSURANCE ID NUMBER:		

MALE FEMALE HEIGHT (IN/CM): _____ WEIGHT (LB/KG): _____ ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI DISCLOSURE AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
 AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION		
LAST NAME:	FIRST NAME:	
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:	
NPI NUMBER:	DEA NUMBER:	
PHONE NUMBER:	FAX NUMBER:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.





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MEMBER'S LAST NAME: _____ MEMBER'S FIRST NAME: _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): 	DURATION OF THERAPY (SPECIFY DATES): 	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES: <input type="checkbox"/> Clinical atherosclerotic cardiovascular disease <input type="checkbox"/> Heterozygous familial hypercholesterolemia (HeFH) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____		ICD-10:
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
<p>For all diagnoses, answer the following:</p> <p>Will Praluent be used as an adjunct to a low-fat diet and exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is Praluent prescribed by, or in consultation with, a cardiologist, endocrinologist or neurologist? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient continuing to receive statin therapy at a maximally tolerated dose? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Will Praluent be used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor, Juxtapid (lomitapide), or Kynamro (mipomersen)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have <u>atherosclerotic cardiovascular disease (ASCVD)</u> that requires additional lowering of LDL-C? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has patient had a history of acute coronary syndromes, history of myocardial infarction, or unstable angina within the past 12months? <input type="checkbox"/> Yes <input type="checkbox"/> No Please provide chart documentation.</p> <p>For heterozygous familial hypercholesterolemia (HeFH), also answer the following:</p> <p>Has there been genetic confirmation of the diagnosis through a mutation identified in the LDL receptor, ApoB or PCSK9? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, does the patient have an untreated/ pre-treatment LDL-C greater than 190 mg/dL? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is there documented evidence of tendinous xanthomas in the patient and/or first-degree relative, and/or second-degree relative? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, is the individual with tendinous xanthomas 18 years of age or older with an untreated/pre-treatment LDL-C greater than 190 mg/mL? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		





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Was the patient assessed with the Dutch Lipid Clinic Network diagnostic criteria and found to have a cumulative score greater than or equal to 9 points (i.e., definite FH)? Yes No
 (If Yes, please submit calculation with final score)

Reauthorization:

If this is a reauthorization request, answer the following questions:

Has the patient been adherent to therapy and is continuing a low-fat diet and exercise regimen? Yes No

Is the patient continuing to receive statin therapy at a maximally tolerated dose? Yes No

Is Praluent prescribed by, or in consultation with, a cardiologist, endocrinologist or neurologist? Yes No

Will Praluent be used in combination with another PCSK9 inhibitor, Juxtapid(lomitapide) or Kynamro(mipomersen)? Yes No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.

4801 E. Washington Street, Phoenix, AZ 85034

Phone: 877-228-7909

