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

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:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	**DURATION OF THERAPY** (SPECIFY DATES):	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Clinical atherosclerotic cardiovascular disease ☐ Heterozygous familial hypercholesterolemia (HeFH) ☐ homozygous familial hypercholesterolemia(HoFH) ☐ Other diagnosis: _____ICD-10 Code(s): _____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

For <u>all diagnoses</u>, answer the following:
Will drug be used as part of a clinical trial? ☐ Yes ☐ No

Will Praluent be used as an adjunct to a low-fat diet and exercise? ☐ Yes ☐ No

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

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

Will Praluent be used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor, Juxtapid (lomitapide), or Kynamro (mipomersen)? ☐ Yes ☐ No

Does the patient have <u>atherosclerotic cardiovascular disease (ASCVD)</u> that requires additional lowering of LDL-C? ☐ Yes ☐ No

Has patient had a history of acute coronary syndromes, history of myocardial infarction, or unstable angina within the past 12months? ☐ Yes ☐ No Please provide chart documentation.

For <u>heterozygous familial hypercholesterolemia (HeFH),</u> also answer the following:
Has there been genetic confirmation of the diagnosis through a mutation identified in the LDL receptor, ApoB or PCSK9? ☐ Yes ☐ No

If Yes, does the patient have an untreated/ pre-treatment LDL-C greater than 190 mg/dL? ☐ Yes ☐ No

Is there documented evidence of tendinous xanthomas in the patient and/or first-degree relative, and/or second-degree relative? ☐ Yes ☐ No

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? ☐ Yes ☐ No

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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)

For homozygous familial hypercholesterolemia (HoFH):
Does patient have one of the following?: ***Please submit genetic/laboratory reports(and/or chart documents).***
□ Documented homozygous or compound heterozygous mutations in both low-density lipoprotein receptor (LDLR) alleles.
□ Presence of homozygous or compound heterozygous mutations in apolipoprotein B (APOB), proprotein convertase subtilisin/kexin type 9 (PCSK9), or low-density lipoprotein receptor adaptor protein 1 (LDLRAP1) alleles
□ Presence of double heterozygous mutations, (i.e., mutations on different genes in the LDLR, APOB, or PCSK9 alleles).
□ Untreated total cholesterol >500 mg/dl (12.93 mmol/l) and triglycerides <300 mg/dl (3.39 mmol/l) AND EITHER (a) OR (b): (a) both biological parents have a history of total cholesterol >250 mg/dl (6.46 mmol/l), OR (b) patient is documented to have had cutaneous or tendinous xanthoma(s) before 10 years of age.

Does patient have documented evidence of a null mutation in both LDLR alleles? □ Yes □ No ***Please submit genetic/laboratory reports(and/or chart documents).***

Does the patient have a low-density lipoprotein cholesterol (LDL C) level greater than or equal to 70 mg/dl (1.81 mmol/l)? □ Yes □ No ***Please submit lab reports.***

Reauthorization for atherosclerotic cardiovascular disease (ASCVD & heterozygous familial hypercholesterolemia (HeFH) :
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

Reauthorization for homozygous familial hypercholesterolemia (HoFH):
Has the patient been adherent to therapy and is continuing a low-fat diet and exercise regimen? □ Yes □ No

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

Does patient have a sustained reduction in LDL-C levels from pre-treatment baseline? □ Yes □ No

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

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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:** _____

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