Repatha (Evolocumab)
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:	

Continued on next page

Repatha (Evolocumab)
Prior Authorization Request Form

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

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.

Clinical Information:

<u>For all diagnoses,</u> answer the following:

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

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

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

<u>For diagnosis of Clinical atherosclerotic cardiovascular disease:</u>

Has the patient been diagnosed with a myocardial infarction (MI) more than 4 weeks from requesting Repatha? ☐ **Yes** ☐ **No** ***<u>Please provide documentation</u>***

Has the patient been diagnosed with a non-hemorrhagic stroke more than 4 weeks from requesting Repatha (NOTE: TIA's do not qualify)? ☐ **Yes** ☐ **No** ***<u>Please provide documentation</u>***

Has the patient been diagnosed with symptomatic peripheral arterial disease as defined by one of the following: intermittent claudication + ankle-brachial index <0.85 -OR- peripheral arterial revascularization procedure -OR- amputation due to atherosclerotic disease? ☐ **Yes** ☐ **No** ***<u>Please provide documentation</u>***

Does patient have at least one of the following major risk factors: ***<u>Please provide documentation</u>***

- ☐ **Diabetes mellitus, type 1 or 2 Please provide documentation**
- ☐ **Age 65 years or older**
- ☐ **MI or non-hemorrhagic stroke (TIAs don't qualify) in the past 6 months**
- ☐ **Current daily cigarette smoker**
- ☐ **History of more than one MI**
- ☐ **History of more than one non-hemorrhagic stroke (TIAs don't qualify)**
- ☐ **History of one MI plus one non-hemorrhagic stroke (TIAs don't qualify)**

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

□ **History of one MI plus history of symptomatic peripheral arterial disease as defined above**

□ **History of one non-hemorrhagic stroke (TIAs don't qualify) plus history of symptomatic peripheral arterial disease as defined above**

IF PATIENT DOES NOT HAVE ANY OF THE ABOVE, does patient have at least 2 of the following minor risk factors below: ***Please provide documentation***

□ **History of non-MI related coronary revascularization**

□ **Residual coronary artery disease with >40% stenosis in at least 2 large vessels**

□ **Metabolic syndrome (as defined by Alberti et al., Circulation, 2009; 120:1640-1645,**

□ **Most recent HDL-C < 40 mg/dL (men) and < 50 mg/dL (women), in the absence of metabolic syndrome or in the presence of metabolic syndrome when 3 of its four non-HDL criteria are met (as per Alberti et al., 2009)**

□ **Most recent hsCRP (high-sensitivity C-reactive protein) > 2.0 mg/L**

□ **Most recent LDL-C > 130 mg/dL or non-HDL-C > 160 mg/dL**

□ **Most recent fasting LDL-C > 70 mg/dL or non-HDL-C > 100mg/dL after > 2 weeks stable lipid lowering therapy**

□ **Most recent fasting triglycerides < 400 mg/dL**

Is patient currently taking one of the following statins? □ **Yes** □ **No**

□ **Atorvastatin 10 mg or more daily, OR**

□ **Simvastatin 20 mg or more daily, OR**

□ **Rosuvastatin 5 mg or more daily, OR**

□ **Pitavastatin 2 mg or more daily, OR**

□ **Pravastatin 40mg or more daily, OR**

□ **Lovastatin 40mg or more daily, OR**

□ **Fluvastatin 80mg or more daily**

Does patient have a history of hemorrhagic stroke? □ **Yes** □ **No** ***Please provide documentation***

Does patient have a history of malignancy in the past 10 years (exceptions: non-melanoma skin cancer, cervical in-situ carcinoma, breast ductal carcinoma in situ, or stage 1 prostate carcinoma)? □ **Yes** □ **No** ***Please provide documentation***

SEE BELOW FOR ADDITIONAL SECTIONS FOR HeFH AND HoFH:

For heterozygous familial hypercholesterolemia (HeFH), 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** ***Please provide documentation***

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

If yes, does patient have an untreated/pre-treatment LDL-C greater than 190 mg/dL? □ Yes □ No *Please provide documentation*

Is there documented evidence of tendinous xanthomas in the patient and/or first-degree relative, and/ or second-degree relative? □ Yes □ No *Please provide documentation*

If Yes, is the individual with tendinous xanthomas a first- or second-degree relative less than 18 years of age with an untreated/pre-treatment LDL-C greater than 155 mg/mL? □ Yes □ No *Please provide documentation*

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 *Please provide documentation*

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.)

Will the patient continue taking a daily statin in combination with Repatha(evolocumab)? □ Yes □ No

Does the patient's fasting LDL-C value within the last 30 days while on a maximally tolerated lipid-lowering regimen equal 100mg/dL or greater? □ Yes □ No *Please provide documentation*

Is the fasting triglyceride level for this patient greater than 400 mg/dL? □ Yes □ No *Please provide documentation*

For homozygous familial hypercholesterolemia (HoFH), also answer the following:

Has there been genetic confirmation of the diagnosis through two mutant alleles identified in the LDL receptor, ApoB, PCSK9 or LDL receptor adaptor protein 1 (LDLRAP1 or ARH)? □ Yes □ No *Please provide documentation*

Does the patient have a untreated/ pre-treatment LDL-C greater than 500 mg/dL? □ Yes □ No *Please provide documentation*

Did the patient have a cutaneous or tendinous xanthoma before the age of ten? □ Yes □ No *Please provide documentation*

Do both of the patient's parents have evidence of heterozygous familial hypercholesterolemia? □ Yes □ No *Please provide documentation*

Has the patient had cellular testing performed which demonstrated a reduced LDL receptor activity in fibroblasts/lymphocytes equaling 20% or less of the normal activity? □ Yes □ No *Please provide documentation*

Will the patient continue taking a daily statin in combination with Repatha(evolocumab)? □ Yes □ No

Repatha (Evolocumab)
Prior Authorization Request Form

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

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

Does the patient's fasting LDL-C value within the last 30 days while on a maximally tolerated lipid-lowering regimen equal 130mg/dL or greater? □ **Yes** □ **No** ***Please provide documentation***

Is the fasting triglyceride level for this patient greater than 400 mg/dL? □ **Yes** □ **No** ***Please provide documentation***

REAUTHORIZATIONS:

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**

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

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

For clinical atherosclerotic cardiovascular disease ,also answer the following:
Does the patient continue to take one of the following DAILY doses of a statin:
Atorvastatin 10mg or more, Simvastatin 20mg or more, Rosuvastatin 5mg or more, Pitavastatin 2mg or more, pravastatin 40mg or more, Lovastatin 40mg or more, Fluvastatin 80mg or more? □ **Yes** □ **No**

For heterozygous familial hypercholesterolemia (HeFH) OR homozygous familial hypercholesterolemia (HoFH), also answer the following:

Is the patient continuing to receive DAILY statin therapy? □ **Yes** □ **No**

Have medical records (e.g., laboratory values) been submitted that document a sustained reduction in LDL-C levels from pre-treatment baseline (i.e., prior to PCSK9 therapy) while on PCSK9 therapy? □ **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.

Repatha (Evolocumab)
Prior Authorization Request Form

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

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

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