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.

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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 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 *Please provide documentation

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

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 *Please provide documentation.

Does patient have diabetes mellitus, type 1 or 2? □ Yes □ No *Please provide documentation

<u>For diagnosis of Heterozygous familial hypercholesterolemia (HeFH) and Homozygous familial hypercholesterolemia (HoFH):</u>

Select if the patient has one of the following fasting LDL-C w ithin the last 30 days w hile on a maximally tolerated lipid-low ering regimen:

- **□ LDL-C greater than or equal to 100 mg/dL but less than 130 mg/dL**
- **□ LDL-C greater than or equal to 130 mg/dL**

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

Is the fasting triglyceride level for this patient greater than or equal to 400 mg/dL? □ Yes □ No

Has the patient's most recent fasting LDL level been confirmed by DIRECT measurement?* □ Yes □ No
Please submit copy of lab report documenting fasting LDL level by DIRECT measurement.

Select if the patient has been receiving at least 12 consecutive weeks of therapy with the following high-intensity statin:
- **□ Atorvastatin 40 mg or 80 mg**
- **□ Rosuvastatin at doses 20 mg or greater**

Will the patient continue to receive high-intensity statin at the maximally-tolerated dose? □ Yes □ No

Select if the patient is unable to tolerate high-intensity statin therapy as evidenced by any of the following:
- **□ Intolerable and persistent (i.e., longer than two weeks) myalgia (muscle symptoms without CK elevations)**
- **□ Intolerable and persistent (i.e., longer than two weeks) myositis (muscle symptoms with CK elevations less than 10 times the upper limit of normal)**
- **□ Other intolerable and persistent (i.e., longer than two weeks) statin intolerance**

Please document the intolerance: _____

Select if the patient has been receiving at least 12 consecutive weeks of therapy with the following moderate-intensity statin:
- **□ Atorvastatin 10 mg or 20 mg**
- **□ Rosuvastatin 5 mg or 10 mg**
- **□ Simvastatin 20 mg or 40 mg**
- **□ Pravastatin 40 mg to 80 mg**
- **□ Lovastatin 40 mg**
- **□ Fluvastatin XL 80 mg**
- **□ Fluvastatin IR 40 mg twice daily**
- **□ Pitavastatin 2 mg or 4 mg**

Will the patient continue to receive a moderate-intensity statin at the maximally-tolerated dose? □ Yes □ No

Select if the patient is unable to tolerate moderate-intensity statin therapy as evidenced by the following:
- **□ Intolerable and persistent (i.e., longer than two weeks) myalgia (muscle symptoms w ithout CK elevations)**
- **□ Intolerable and persistent (i.e., longer than two weeks) myositis (muscle symptoms with CK elevations less than 10 times the upper limit of normal)**
- **□ Other intolerable and persistent (i.e., longer than two weeks) statin intolerance**

Please document the intolerance: _____

Select if the patient has been receiving at least 12 consecutive w eeks of the follow ing low-INTENSITY statin:
- **□ Simvastatin 10 mg**
- **□ Pravastatin 10 mg or 20 mg**
- **□ Lovastatin 20 mg**
- **□ Fluvastatin IR 20 mg or 40 mg**
- **□ Pitavastatin 1 mg**

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

Will the patient continue to receive a low-intensity statin at maximally tolerated doses? □ Yes □ No

Select if the patient is unable to tolerate low-intensity statin therapy as evidenced by the following:

- **□ Intolerable and persistent (i.e., longer than two weeks) myalgia (muscle symptoms without CK elevations)**
- **□ Intolerable and persistent (i.e., longer than two weeks) myositis (muscle symptoms with CK elevations less than 10 times the upper limit of normal)**
- **□ Other intolerable and persistent (i.e., longer than two weeks) statin intolerance**
  Please document the intolerance: _____

Has the patient undergone statin re-challenge with pravastatin 10 mg, Crestor (rosuvastatin) 5 mg or fluvastatin 10 mg with documented reappearance of muscle symptoms during upward titration? □ Yes □ No

Has the patient experienced rhabdomyolysis or muscle symptoms with CK elevations greater than 10 times ULN? □ Yes □ No

Does the patient have a labeled contraindication to all statins that is documented in the patient's medical records? □ Yes □ No

Has the patient been receiving at least 12 consecutive weeks of therapy with ezetimibe or a bile acid sequestrant as an adjunct to a maximally tolerated statin? □ Yes □ No

If Yes to the above question, will the patient continue to receive ezetimibe or bile acid sequestrant therapy? □ Yes □ No

If No to the above question, does the patient have an absolute contraindication to or history of intolerance to ezetimibe AND bile acid sequestrant therapy? □ Yes □ No

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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

If yes, does 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 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

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

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.)

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

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

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

Does the patient have a treated LDL-C greater than 300 mg/dL? □ Yes □ No

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

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

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

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, or does the patient have a documented inability to take statins? □ Yes □ No

Is the patient continuing to receive ezetimibe or bile acid sequestrant therapy, or does the patient have a documented inability to take ezetimibe and bile acid sequestrant? □ Yes □ No

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

For clinical atherosclerotic cardiovascular disease or heterozygous familial hypercholesterolemia (HeFH), also answer the following:
Have medical records (e.g., laboratory values) been submitted that document a sustained reduction of more than 30% in LDL-C levels from pre-treatment baseline (i.e., prior to PCSK9 therapy) while on PCSK9 therapy? □ Yes □ No

Will Repatha be used in combination with another PCSK9 inhibitor? □ Yes □ No

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

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

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Will Repatha 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:** _____

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