



**PRESCRIPTION DRUG
MEDICATION REQUEST FORM
FAX TO 1-866-240-8123**

PCSK9 Inhibitors: Repatha® (evolocumab) & Praluent® (alirocumab)

Patient Information:

Subscriber's ID Number		Subscriber's Group Number	
Patient's Name		Phone	Date of Birth
Address	City	State	Zip Code

Provider Information:

Physician's Name	NPI	Phone	Fax
Address	City	State	Zip Code
Suite / Building	Physician's Signature		Date

Medication Information:

<p>Please specify the medication being requested:</p> <p><input type="checkbox"/> Repatha Syringe 140mg/ml <input type="checkbox"/> Praluent Pen 75mg/ml</p> <p><input type="checkbox"/> Repatha Sureclick 140mg/ml <input type="checkbox"/> Praluent Pen 150mg/ml</p> <p><input type="checkbox"/> Repatha Pushtonex 420mg/3.5ml</p>	<p>Requested quantity <i>per month</i>: _____</p>
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Clinical Criteria:

<p>Please provide a diagnosis and/or ICD-10 code(s): _____</p>			
<p>1. Repatha or Praluent is being prescribed by (or in consultation with) a:</p> <p><input type="checkbox"/> Cardiologist <input type="checkbox"/> Endocrinologist <input type="checkbox"/> Lipid Specialist <input type="checkbox"/> Other _____</p>			
<p>2. Does the patient have atherosclerotic cardiovascular disease (ASCVD)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, please check all that apply:</p> <p><input type="checkbox"/> History of myocardial infarction (MI) <input type="checkbox"/> History of stroke or transient ischemic attack (TIA)</p> <p><input type="checkbox"/> Acute Coronary syndrome (ACS) <input type="checkbox"/> Peripheral arterial disease (PAD)</p> <p><input type="checkbox"/> Stable or unstable angina <input type="checkbox"/> Coronary or other arterial revascularization procedure</p>			
<p>3. Does the patient have homozygous familial hypercholesterolemia (HoFH)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, please check all that apply:</p> <table border="1" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p><input type="checkbox"/> Untreated LDL-C greater than 400 mg/dL</p> <p><input type="checkbox"/> Untreated total cholesterol greater than 500 mg/dL</p> <p><input type="checkbox"/> Genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus</p> </td> <td style="width: 50%; vertical-align: top;"> <p><input type="checkbox"/> There is evidence of heterozygous familial hypercholesterolemia in both of the patient's parents</p> <p><input type="checkbox"/> The patient had cutaneous or tendon xanthoma before 10 years of age</p> </td> </tr> </table>		<p><input type="checkbox"/> Untreated LDL-C greater than 400 mg/dL</p> <p><input type="checkbox"/> Untreated total cholesterol greater than 500 mg/dL</p> <p><input type="checkbox"/> Genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus</p>	<p><input type="checkbox"/> There is evidence of heterozygous familial hypercholesterolemia in both of the patient's parents</p> <p><input type="checkbox"/> The patient had cutaneous or tendon xanthoma before 10 years of age</p>
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4. Does the patient have heterozygous familial hypercholesterolemia (HeFH)? Yes No

If **YES**, please check all that apply:

<input type="checkbox"/> Untreated LDL-C greater than or equal 190 mg/dL	<input type="checkbox"/> WHO criteria/Dutch Lipid Clinical Network score greater than 8 points
<input type="checkbox"/> Untreated LDL-C greater than or equal 160 mg/dL before 20 years of age	<input type="checkbox"/> Familial hypercholesterolemia possibility of "definite" based on the Simon Broome register
<input type="checkbox"/> Genetic confirmation of one mutant allele at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus	<input type="checkbox"/> Familial hypercholesterolemia possibility of "definite" on the Make Early Diagnosis to Prevent Early Deaths (MEDPED) tool
<input type="checkbox"/> The patient experienced tendon corneal arcus prior to age 45 years, tendon xanthoma, tuberous xanthoma, or xanthelasma	

5. Does the patient have primary hyperlipidemia that is not associated with ASCVD, HeFH, or HoFH?

If **YES**:

a. Prior to the start of Repatha (evolocumab) or Praluent (alirocumab) therapy, did the patient have a coronary artery calcium or calcification (CAC) score greater than or equal to 300 Agatston units?

Yes No

6. Has the patient experienced therapeutic failure to a maximally tolerated statin? Yes No

7. Is the patient **statin intolerant**? Yes No

If **YES**, please answer the following:

a. Has the patient experienced statin-related rhabdomyolysis or skeletal-related muscle symptoms while receiving at least two separate trials of different statins? Yes No

b. Please indicate if the patient has experienced any of the following during statin therapy:

CK (Creatinine kinase) increase to 10 times upper limit of normal

LFTs (Liver Function Tests) increase to 3 times upper limit of normal

Hospitalization due to a statin-related adverse event such as rhabdomyolysis

8. If this request is for Praluent (alirocumab), has the patient experienced therapeutic failure or intolerance to Repatha (evolocumab)? Yes No

9. Please provide the patient's **pretreatment** LDL-C level (prior to therapy with Repatha or Praluent):

Pretreatment LDL-C: _____mg/dL Date of lipid panel: _____

10. Is the patient currently established on therapy with Repatha or Praluent? Yes No

If **YES**:

a. Please specify how long the patient has been on therapy: _____

b. Please provide the patient's **current** LDL-C level (after therapy with Repatha or Praluent):

Current LDL-C: _____mg/dL Date of lipid panel: _____

11. Will the patient continue to receive concurrent lipid-lowering therapies?

Yes No

12. Please provide any additional information for this request (e.g. previously tried medications, medical necessity rationale, etc.):

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Complete **ALL** information on the form.
NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
3. Please provide the physician address as it is required for physician notification.
4. Fax the **completed** form and all clinical documentation to **1-866-240-8123**
Or mail the form to: **Clinical Services,**
120 Fifth Avenue, MC PAPHM-043B, Pittsburgh, PA 15222