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Medication Prior Authorization Form
Fax to 1-866-240-8123

Repatha

Member Information:

Subscriber's ID Number			Subscriber's Group Number
Member'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:

Please specify the medication being requested:	Requested Number of Pens/Syringes:	Requested Day Supply:
☐Repatha Syringe 140mg/ml ☐Repatha Sureclick 140mg/ml ☐Repatha Pushtronex 420mg/3.5ml		☐28 days ☐84 days ☐Other: _____
Directions		
Diagnosis and/or ICD-10 code(s)		

Clinical Information:

1. Repatha is being prescribed by (or in consultation with) a:

   ☐ Cardiologist ☐ Lipid Specialist ☐ Endocrinologist ☐ Other: _____

2. Please indicate if the member has any of the following:

   ☐ History of myocardial infarction
   ☐ History of stroke
   ☐ History of transient ischemic attack
   ☐ Stable or unstable angina
   ☐ Acute Coronary syndrome
   ☐ Coronary or other arterial revascularization procedure
   ☐ Peripheral arterial disease presumed to be of atherosclerotic origin (including descending thoracic and abdominal aortic aneurysm)

3. Is the member at risk for a major cardiovascular event?	Yes	No
3a. If the member is at risk for a major cardiovascular event, please check all that apply: ☐ Atherosclerotic cerebrovascular disease ☐ Peripheral arterial disease ☐ Coronary artery disease ☐ High risk diabetes mellitus		
4. Is Repatha being used for primary prevention of cardiovascular events?	Yes	No
5. Does the member have homozygous familial hypercholesterolemia (HoFH)?	Yes	No
5a. If the member has **homozygous familial hypercholesterolemia**, please check all that apply:		
☐ Untreated LDL-C greater than 400 mg/dL ☐ Untreated total cholesterol greater than 500 mg/dL ☐ Genetic confirmation of two mutant alleles at the LDLR, ApoB, PCSK9, or LDLRAP1 (also known as ARH) gene locus ☐ There is evidence of heterozygous familial hypercholesterolemia in both of the member's parents ☐ The member had cutaneous or tendon xanthoma before 10 years of age ☐ The member had aortic valve disease or xanthomata at less than 20 years of age ☐ One or both of the member's parents have clinically diagnosed HoFH, positive genetic testing for a known LDL-C–raising (for example, LDLR, Apo[b], PCSK9) gene defect, or autosomal-recessive familial hypercholesterolemia		
6. Does the member have heterozygous familial hypercholesterolemia (HeFH)?	Yes	No
6a. If the member has **heterozygous familial hypercholesterolemia**, please check all that apply:		
☐ Untreated LDL-C greater than or equal to 190 mg/dL ☐ Untreated LDL-C greater than or equal to 160 mg/dL before 20 years of age ☐ Genetic confirmation of one mutant allele at the LDLR, ApoB, PCSK9, or LDLRAP1 (also known as ARH) gene locus ☐ Member experienced corneal arcus prior to age 45 years, tendon xanthoma, tuberous xanthoma, or xanthelasma ☐ WHO criteria/Dutch Lipid Clinical Network score greater than 8 points ☐ Familial hypercholesterolemia possibility of "definite" based on the Simon Broome register ☐ Familial hypercholesterolemia possibility of "definite" on the Make Early Diagnosis to Prevent Early Deaths (MEDPED) tool		
7. Does the member have hypercholesterolemia that is **not** associated with ASCVD, HeFH, or HoFH?	Yes	No
8. Does the member have subclinical atherosclerosis?	Yes	No

9. Has the member experienced therapeutic failure to a maximally tolerated statin?	Yes	No
10. Has the member had a less than 50% reduction in baseline LDL-C despite use with maximally tolerated statin therapy?	Yes	No
11. Is the member intolerant of statins?	Yes	No
If the member is intolerant of statins, please answer the following:		
11a. Has the member experienced statin-related rhabdomyolysis or skeletal-related muscle symptoms while receiving at least two separate trials of different statins (which resolved upon discontinuation of the statins)?	Yes	No
11b. Please indicate if the member has experienced any of the following during statin therapy: ☐ Creatine Kinase (CK) increase to 10 times upper limit of normal ☐ Liver Function Tests (LFTs) increase to 3 times upper limit of normal ☐ Hospitalization due to a statin-related adverse event such as rhabdomyolysis		
12. Prior to starting therapy with Repatha, did the member have a baseline untreated LDL greater than or equal to 190 mg/dL?	Yes	No
13. Please provide the member's CAC* score (prior to therapy with Repatha): _____ Agatston units *Coronary Artery Calcification		
14. Please provide the member's **pretreatment** non-HDL-C level (prior to therapy with Repatha): **Pretreatment** non-HDL-C: _____ mg/dL Date of testing: _____		
15. Please provide the member's **pretreatment** apolipoprotein B level (prior to therapy with Repatha): **Pretreatment** apolipoprotein B: _____ mg/dL Date of testing: _____		
16. Please provide the member's **pretreatment** Lipoprotein(a) level (prior to therapy with Repatha): **Pretreatment** Lipoprotein(a): _____ nmol/L Date of testing: _____		

17. Please provide the member's **pretreatment** LDL-C level (prior to therapy with Repatha):

Pretreatment LDL-C: _____ mg/dL Date of testing: _____

18. Is the member currently on therapy with Repatha?	Yes	No

If the member is **currently on therapy with Repatha**, please answer the following:

18a. Please specify how long the member has been on therapy with Repatha: _____

18b. Please provide the member's **current** LDL-C level (after therapy with Repatha):

Current LDL-C: _____ mg/dL Date of testing: _____

18c. Does the member require continued therapy with Repatha?	Yes	No
19. Will the member continue to receive concurrent lipid-lowering therapies for the treatment of their condition?	Yes	No

20. Please provide any major ASCVD events or high-risk conditions the member has:

_____

_____

_____

Medication History:

Please provide any other medications that the member has tried and failed:

_____

_____

The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the member. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

INSTRUCTIONS FOR COMPLETING THIS FORM

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

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