coordinated care

Antihyperlipidemics – Proprotein Convertase Subtilisin Kexin type 9 (PCSK-9) Inhibitors

Please fax this completed form to (833) 645-2734 OR mail to: Pharmacy Services | 5 River Park Place East, Suite 210 | Fresno, CA 93720.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Indicate patient's diagnosis:
   - ☐ Primary Hypercholesterolemia
   - ☐ Heterozygous Familial Hypercholesterolemia (HeFH)
   - ☐ Secondary Prophylaxis in Adults with Established Cardiovascular Disease (CVD)

     Does the patient have a history of any of the following clinical atherosclerotic cardiovascular diseases (ASCVD)? (Check all that apply)

     - ☐ Acute coronary syndrome (ACS)
     - ☐ Angina
     - ☐ Cerebrovascular accident (CVA)
     - ☐ Coronary revascularization procedures
     - ☐ Myocardial infarction (MI)
     - ☐ Transient ischemic attack (TIA)
     - ☐ Peripheral arterial disease (PAD)
   - ☐ Homozygous Familial Hypercholesterolemia (HoFH)
   - ☐ Other. Specify:

2. What was the baseline LDL prior to any treatment? _____ mg/dL

3. What is the current LDL? _____ mg/dL

4. What is the patient specific LDL goal? _____ mg/dL

5. Please indicate which applies to your patient and answer the corresponding questions:

   ☐ Patient completed at least 6 consecutive weeks of the highest tolerated statin regimen with ezetimibe
   - What is the current statin regimen (name and strength): _____
   - What was the patients LDL after at least 6 weeks? _____ mg/dL
   - Did patient achieve at least a 50% LDL reduction from baseline? ☐ Yes ☐ No
   - What other statin regimens (name and strength) were attempted? _____

   ☐ Patient is statin intolerant
   - What statin regimens (name and strength) were attempted? _____
   - What were the reasons leading to discontinuation? _____

6. Will patient be continuing on the statin listed on question #5 while on a PCSK9 Inhibitor? ☐ Yes ☐ No

7. Will this be used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor? ☐ Yes ☐ No

8. Indicate all PCSK9 inhibitors patient has tried and failed with reason for discontinuation:

9. Is this prescribed by a provider specializing in lipid management (e.g. cardiologist, endocrinologist or lipid specialist)? ☐ Yes ☐ No

   If no, has there been a consultation with a provider specializing in lipid management (e.g. cardiologist, endocrinologist or lipid specialist)? ☐ Yes ☐ No
   If yes, please provide consultation note

For diagnosis of homozygous familial hypercholesterolemia (HoFH):

10. Please indicate which of the following applies to your patient and answer the corresponding questions:

    ☐ The patient has a history of untreated LDL ≥500mg/dL for adults, untreated LDL ≥400mg/dL for children, or treated LDL ≥300mg/dL for adults and children.
        ☐ A xanthoma before 10 years of age
        ☐ Evidence of heterozygous familial hypercholesterolemia in both parents
    ☐ Genetic typing confirming presence of familial hypercholesterolemia genes
    ☐ Other. Specify: _____

11. Will this be used in combination with Juxtapid (lomitapide)? ☐ Yes ☐ No

For diagnosis primary Hypercholesterolemia / heterozygous familial hypercholesterolemia (HeFH):

12. Indicate what diagnostic tool (e.g., US MedPod, Simon Broome, etc.) or genetic typing was used to confirm diagnosis:

13. For adults: Does patient have any of the following (check all that apply):
    ☐ Coronary heart disease
    ☐ Diabetes

For re-authorization requests for all diagnoses answer the questions below. Chart notes and labs documenting clinical benefit in continuing a PCSK9 Inhibitor is required for re-authorization.

14. Will the patient continue to receive the maximum tolerated dose of statin, unless contraindicated or intolerant to statin therapy? ☐ Yes ☐ No
15. What is the current LDL? _____
16. What is the patient-specific LDL goal? _____
17. Has patient had at least a 30% reduction in LDL or an achievement of a patient specific goal since initiation of a PCSK9 Inhibitor? ☐ Yes ☐ No

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date

Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)