

PCSK9 INHIBITORS PRIOR AUTHORIZATION FORM

Prior authorization guidelines and quantity limits for **PCSK9 Inhibitors (Lipotropics, Other)** and **Quantity Limits/Daily Dose Limits** are accessible on the Department's Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request: _____	Prescriber name: _____		
<input type="checkbox"/> Renewal request	(PA# _____)				
Name of office contact: _____			Specialty: _____		
Contact's phone number: _____			State license #: _____		
LTC facility contact/phone: _____			NPI: _____	MA Provider ID#: _____	
RECIPIENT INFORMATION			Street address: _____		
Recipient Name: _____			Suite #: _____	City/state/zip: _____	
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____		

CLINICAL INFORMATION

Preferred medication requested (clinical prior authorization required):		<input type="checkbox"/> Repatha auto injector	<input type="checkbox"/> Repatha prefilled syringe
Non-preferred medication requested:		<input type="checkbox"/> Praluent pen injector	<input type="checkbox"/> Praluent prefilled syringe
Strength: _____	Dose/directions: _____	Quantity: _____	Refills: _____
Diagnosis (<i>submit documentation</i>): _____		Dx code (<i>required</i>): _____	
Which specialty pharmacy will be used? <input type="checkbox"/> Diplomat Specialty Pharmacy <input type="checkbox"/> Walgreen's Specialty Pharmacy ¹			
ALL requests (initial and renewal)			
1. <i>Submit documentation</i> supporting the Recipient's diagnosis, including:		<input type="checkbox"/> lab results	<input type="checkbox"/> chart notes
2. Was the Recipient counseled regarding standard lipid-lowering lifestyle interventions, including physical activity and a low-fat, low-cholesterol diet?		<input type="checkbox"/> Yes – <i>submit documentation</i> . <input type="checkbox"/> No	
3. If the requested medication is being prescribed <i>in consultation with</i> a specialist, <i>submit documentation</i> of consultation and consultant's specialty.			
4. List all lipid-lowering medications and doses the Recipient will use in conjunction with the requested agent? <i>Indicate specific agents and submit documentation of current medication list and treatment plan.</i>			
All INITIAL requests			
5. What is the Recipient's goal LDL-C? _____ mg/dL			
6. Does the Recipient have a history of trial and failure, contraindication, or intolerance of maximum tolerated doses of other lipid-lowering medications?		<input type="checkbox"/> Yes – <i>submit all supporting documentation of previous and current lipid-lowering medication regimen, including treatment outcomes, contraindications, or intolerances.</i> <input type="checkbox"/> No	
7. Has the Recipient experienced intolerance to statins?		<input type="checkbox"/> Yes – <i>submit documentation and continue to next question.</i> <input type="checkbox"/> No – <i>submit request to the Department.</i>	
8. Were the following conditions associated with statin intolerance ruled out or corrected? <i>Check all that apply.</i>		<input type="checkbox"/> Yes – <i>submit documentation for each condition.</i> <input type="checkbox"/> No	
<input type="checkbox"/> hypothyroidism <input type="checkbox"/> vitamin D deficiency <input type="checkbox"/> acute or chronic renal impairment <input type="checkbox"/> obstructive liver disease			
9. Was the Recipient's medication regimen evaluated for potential drug interactions with statins, and were all interactions addressed?		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation of Recipient's current medication list, evaluation for interactions, and subsequent changes to medication therapy.</i>	
10. Praluent requests: Does the Recipient have a history of trial and failure, contraindication, or intolerance to the preferred PCSK9 inhibitor, Repatha ?		<input type="checkbox"/> Yes – <i>submit all supporting documentation.</i> <input type="checkbox"/> No	
All RENEWAL requests			
1. Did the Recipient's LDL-C decrease since starting the requested medication?		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit results of baseline (before PCSK9 inhibitor) and currently lab results.</i>	

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____	Date: _____
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