pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

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**	
☐New request ☐Renewal request	# of pages: ___________	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested:
☐Praluent *(indicate formulation)*: ☐pen ☐other: ______________________
☐Repatha *(indicate formulation)*: ☐Pushtronex ☐SureClick ☐syringe ☐other: ______________________

Strength:	Dose/directions:	Quantity:	Refills:

Diagnosis (*submit documentation*):	Dx code (*required*):
Which specialty pharmacy will be used? ☐Diplomat Specialty ☐Walgreen's Specialty	Goal LDL-C: ________________ mg/dL

ALL requests (initial and renewal)

1. *Submit documentation* supporting the beneficiary's diagnosis, including: ☐lab results ☐chart notes
2. Was the beneficiary counseled regarding standard lipid-lowering lifestyle interventions, including physical activity and a low-fat, low-cholesterol diet? ☐Yes – *Submit documentation.* ☐No
3. If the requested medication is being prescribed *in consultation with* a specialist, *submit documentation* of consultation and consultant's specialty.
4. List all lipid-lowering medications and doses the beneficiary will use in conjunction with the requested agent? *Indicate specific agents, and submit documentation of current medication list and treatment plan.*

All INITIAL requests

Question	Response
1. Does the beneficiary have a history of trial and failure, contraindication, or intolerance of maximum tolerated doses of other lipid-lowering medications?	☐Yes – *Submit all supporting documentation of previous and current lipid-lowering medication regimen, including treatment outcomes, contraindications, or intolerances.* ☐No
2. Does the beneficiary have a contraindication or intolerance to statins?	☐Yes ☐No *Submit documentation supporting statin contraindication or intolerance, if applicable.*
3. Were the following conditions associated with statin intolerance ruled out or corrected? *Check all that apply.* ☐hypothyroidism ☐vitamin D deficiency ☐acute or chronic renal impairment ☐obstructive liver disease	☐Yes – *Submit documentation for each condition.* ☐No
4. Was the beneficiary's medication regimen evaluated for potential drug interactions with statins, and were all interactions addressed?	☐Yes ☐No *Submit documentation of beneficiary's current medication list, evaluation for interactions, and subsequent changes to medication therapy.*

All RENEWAL requests

Question	Response
1. Did the beneficiary's LDL-C decrease since starting the requested medication?	☐Yes ☐No *Submit results of baseline (before PCSK9 inhibitor) and currently lab results.*

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

Prescriber Signature:	**Date**:

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