

## PCSK9 INHIBITORS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Lipotropics, Other** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	# of pages: _____	Prescriber name:
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

### CLINICAL INFORMATION

<b>Medication requested:</b>	<input type="checkbox"/> Praluent ( <i>indicate formulation</i> ):	<input type="checkbox"/> pen	<input type="checkbox"/> other: _____	
	<input type="checkbox"/> Repatha ( <i>indicate formulation</i> ):	<input type="checkbox"/> Pushtrex	<input type="checkbox"/> SureClick	<input type="checkbox"/> syringe
			<input type="checkbox"/> other: _____	
Strength:	Dose/directions:	Quantity:	Refills:	
Diagnosis ( <i>submit documentation</i> ):			DX code ( <i>required</i> ):	

#### ALL requests (initial and renewal)

List all lipid-lowering medications and doses the beneficiary will use in conjunction with the requested PCSK9 inhibitor.

What is the beneficiary's goal LDL-C or goal reduction in LDL-C? \_\_\_\_\_ mg/dL **OR** \_\_\_\_\_ % reduction

#### All INITIAL requests

Does the beneficiary have a history of trial and failure or intolerance of maximum tolerated doses of 2 different high-intensity statins (i.e., atorvastatin, rosuvastatin) in combination with ezetimibe?

Yes     *Submit documentation of previous and current lipid-lowering medication regimens, including treatment outcomes, contraindications, or intolerances.*  
 No

***If unable to tolerate high-intensity statins***, does the beneficiary have a history of trial and failure or intolerance of low- or medium-intensity statins at any dose in combination with ezetimibe?

Yes     *Submit documentation.*  
 No

Does the beneficiary have active liver disease or unexplained persistent elevations in hepatic transaminase levels?

Yes     *Submit documentation.*  
 No

Is the beneficiary pregnant or breastfeeding?

Yes     *Submit documentation.*  
 No

Were the following conditions associated with statin intolerance ruled out or addressed? *Check all that apply.*

<input type="checkbox"/> hypothyroidism	<input type="checkbox"/> vitamin D deficiency
<input type="checkbox"/> acute or chronic renal impairment	<input type="checkbox"/> obstructive liver disease
<input type="checkbox"/> drug-drug interactions	

Yes     *Submit documentation.*  
 No

#### All RENEWAL requests

Did the beneficiary's LDL-C decrease since starting the requested medication?

Yes     *Submit documentation.*  
 No

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

<b>Prescriber Signature:</b>	<b>Date:</b>
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