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. You can also complete online at CoverMyMeds.com.

| | | | |
|---|---|---|---|
| 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

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**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.)