

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

Please fax this completed form to (866) 399-0929 OR mail to: Envolve Pharmacy Solutions PA Department | 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:
 - Heterozygous Familial Hypercholesterolemia (HeFH)
 - Secondary Prophylaxis in Adults with Established Cardiovascular Disease (CVD)
 Is patient very high risk, defined as multiple major ASCVD events or major ASCVD event and multiple high-risk conditions? Yes No
 - 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 8 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 PCSK9 Inhibitor? Yes No

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

8. 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 re-authorization requests only: Chart notes and labs documenting clinical benefit in continuing a PCSK9 Inhibitor is required for re-authorization.

9. What is the current LDL? _____
10. What is the patient-specific LDL goal? _____
11. 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

Envolve Pharmacy Solutions 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.)