{{PANUMCODE}}

{{DISPLAY_PAGNAME}}
{{PACDESCRIPTION}}

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} **Patient Phone:** <<MEMPHONE>>
Specialty: _____ **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: <<DIAGNOSIS>> **ICD Code**: <<ICD9>>

1. What is the prescribed drug?
   ❑ Praluent ❑ Repatha
2. What is the diagnosis?
   ❑ Clinical atherosclerotic cardiovascular disease (ASCVD)
   ❑ Primary hyperlipidemia
   ❑ Familial hypercholesterolemia (heterozygous familial hypercholesterolemia [HeFH] or homozygous familial hypercholesterolemia [HoFH])
   ❑ Other _____
3. What is the ICD-10 code? _____
4. Is this request for continuation of therapy with a PCSK9 inhibitor? ❑ Yes ❑ No *If No, skip to #7*
5. Does the patient have a current LDL-C level drawn within the past 6 months? ***ACTION REQUIRED: Attach chart notes indicating the current treated LDL-C level. The LDL-C level must be dated within the six months preceding the authorization request.***
   ❑ Yes - Current LDL-C level:_____ ❑ No or Unknown
6. Has the patient achieved or maintained an LDL-C reduction (e.g., LDL-C is now at goal, robust lowering of LDL-C) as a result of PCSK9 inhibitor therapy? ❑ Yes ❑ No *No further questions.*
7. What is the current LDL-C level in mg/dL? ***ACTION REQUIRED: Attach chart notes indicating the current LDL-C level. The LDL-C level must be dated within the six months preceding the authorization request.*** _____mg/dL ❑ Unknown
8. What is the patient's untreated (before any lipid-lowering therapy) LDL-C level? ***ACTION REQUIRED: Attach chart notes indicating the untreated LDL-C level.***
   _____mg/dL ❑ Unknown
9. Are there any secondary causes that could explain the elevated untreated LDL-C? ❑ Yes ❑ No
10. Is the patient receiving a high-intensity statin dose daily, such as rosuvastatin (Crestor) 20 mg daily or atorvastatin (Lipitor) 40 mg daily? ❑ Yes ❑ No
11. Has the patient received this dose for at least 3 months? ❑ Yes ❑ No

12. Does the patient have either of the following?
❑ An intolerance to a high-intensity statin ❑ A contraindication to statin therapy ❑ None of the above

13. Is the patient receiving a moderate-intensity statin dose daily, such as atorvastatin (Lipitor) 20 mg or equivalent? ❑ Yes ❑ No

14. Has the patient received this statin dose in combination with ezetimibe for at least 3 months?
❑ Yes ❑ No

15. Did the patient score a 7 or higher on the Statin-Associated Muscle Symptom Clinical Index (SAMS-CI) and failed statin rechallenge? ***ACTION REQUIRED: If Yes, attach chart notes or medical record documentation confirming the SAMS-CI score and failed rechallenge with statin therapy.*** ❑ Yes ❑ No

16. Did the patient experience a statin-associated increase in creatine kinase (CK) level of greater than or equal to 10 times the upper limit of normal (ULN) during previous treatment with a statin?
ACTION REQUIRED: If Yes, attach chart notes or medical record documentation confirming the CK level.
❑ Yes ❑ No

17. Did the patient experience statin-associated muscle symptoms with increase in creatine kinase (CK) level of greater than or equal to 3 times the upper limit of normal (ULN) during previous treatment with a statin?
ACTION REQUIRED: If Yes, attach chart notes or medical record documentation of muscle symptoms and confirming the CK level. ❑ Yes ❑ No

18. Does the patient have any of the following contraindications to statins?
ACTION REQUIRED: If Yes, attach chart notes or medical record documentation confirming the contraindication.
❑ Yes - Active liver disease, including unexplained persistent elevations in hepatic transaminase levels (e.g., alanine transaminase [ALT] level greater than or equal to 3 times upper limit of normal)
❑ Yes - Currently pregnant or planning pregnancy
❑ Yes - Breastfeeding
❑ None of the above

Complete the following section based on the patient's <u>primary</u> diagnosis, if applicable.

<u>Section A: Clinical Atherosclerotic Cardiovascular Disease (ASCVD),</u>

1. Which of the following manifestations of clinical atherosclerotic cardiovascular disease (ASCVD) has the patient experienced? *List continues on next page.*
ACTION REQUIRED: Attach chart notes confirming clinical atherosclerotic cardiovascular disease.
❑ Acute coronary syndromes
❑ Myocardial infarction
❑ Stable or unstable angina
❑ Stroke of presumed atherosclerotic origin
❑ Transient ischemic attack (TIA)
❑ Coronary Artery Calcium (CAC) score of greater than or equal to 300
❑ Coronary or other arterial revascularization procedure (e.g., percutaneous coronary intervention [PCI], coronary artery bypass graft [CABG] surgery)
❑ Non-cardiac peripheral arterial disease of presumed atherosclerotic origin (e.g., carotid artery stenosis, lower extremity PAD)
❑ Obstructive coronary artery disease (defined as fifty percent or greater stenosis on cardiac computed tomography angiogram or catheterization)
❑ Other:_____

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____
Prescriber (Or Authorized) Signature and Date