BlueCross BlueShield
Federal Employee Program

PRALUENT
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

All approved requests are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage.

For Standard Option patients Repatha is a preferred product. Please consider prescribing the preferred product.
Standard Option patients who switch to the preferred product will be eligible for 2 copays at no cost in the benefit year.

Praluent (alirocumab)

NOTE: Form must be completed in its **entirety** for processing

Please select strength: ❑**75 mg** ❑**150 mg**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 3**
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Will the patient need more than 6 syringes every 90 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ syringes every 90 days
4. **Standard Option Patient:** Would you like to participate in this program and switch the patient to Repatha? ***Select answer below:***
   ❑**Yes** ***(please select strength)***: ❑Repatha 140mg **OR** ❑Repatha 420mg
   ❑**No**: Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to Repatha?
   ❑**Yes** ***(specify result)***: _____
   ❑**No**: Is there a clinical reason for not trying Repatha? ❑Yes* ❑No
   If YES, please specify: _____
5. Will the patient be assessed for response, such as LDL-C reduction, and adherence to the prescribed lipid lowering regimen after 3 months? ❑Yes ❑No
6. Has the patient had documented prior therapy for 3 months with at least **ONE** *high intensity statin? ❑Yes ❑No
   High-Intensity Statins: atorvastatin (Lipitor) 40-80mg/day, rosuvastatin (Crestor) 20-40mg/day
7. Does the patient have a documented intolerance or contraindication to statin therapy? ❑Yes ❑No
8. Will Praluent be used in combination with another *Prior Authorization (PA) lipid lowering agent? ❑Yes* ❑No
   If YES, please specify the medication: _____
   PA Lipid Lowering Agents: Juxtapid (lomitapide), Leqvio (inclisiran), Nexletol (bempedoic acid), Nexlizet (bempedoic acid/ezetimibe), Repatha (evolocumab)

PLEASE PROCEED TO PAGE 2 FOR DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

9. What is the patient's diagnosis?

❑ Atherosclerotic cardiovascular disease (ASCVD) **OR** ❑ Hypercholesterolemia **OR** ❑ Hyperlipidemia

a. Has the patient been assessed for high risk of ASCVD or cardiovascular event based on a 10 year risk score by either the ASCVD Pooled Cohort Risk Assessment or the Predicting risk of cardiovascular disease EVENTs (PREVENT) Score? ❑Yes* ❑No

If YES, please select the tool used below and provide the score:

❑ ASCVD Pooled Cohort Risk Assessment Score: _____ %

❑ Predicting risk of cardiovascular disease EVENTs (PREVENT) Score: _____ %

b. Has the patient had at least **ONE** of the following ASCVD or cardiovascular events listed below:

❑**None of the events listed**	❑Coronary or other arterial revascularization procedure (such as PTCA or CABG)
❑Acute coronary syndrome (ACS)	❑Findings from CT angiogram or catheterization consistent with clinical ASCVD
❑Myocardial infarction (MI)	❑Peripheral arterial disease (PAD) presumed to be of atherosclerotic origin
❑Stable or unstable angina	❑Transient ischemic attack (TIA)

c. Does the patient have a drawn LDL-C level greater than or equal to 70 mg/dL in the last 6 months? ❑Yes ❑No

❑ Heterozygous familial hypercholesterolemia (HeFH)

a. Does the patient have a confirmed diagnosis by LDL-R DNA Sequencing Test or APOB (hypercholesterolemia) Mutation Analysis? ***Please select answer below:***

❑**Yes** ***(please select test)***: ❑ LDL-R DNA Sequencing Test **OR** ❑ APOB Mutation Analysis

❑**No:** Does the patient have a Dutch Lipid Clinic Network Criteria score greater than 5? ❑Yes ❑No*

***If NO**, does the patient have a confirmed diagnosis per Simon-Broome Diagnostic Criteria for definite familial hypercholesterolemia? ❑Yes ❑No

b. Does the patient have a drawn LDL-C level greater than or equal to 100 mg/dL in the last 6 months? ❑Yes ❑No

❑ Homozygous familial hypercholesterolemia (HoFH)

a. Does the patient have genetic confirmation of two mutant alleles at the LDLR, Apo-B, PCSK9, ARH adaptor protein 1/LDLRAP1 gene locus? ❑Yes ❑No

b. Does the patient have a confirmed diagnosis by LDL-R DNA Sequencing Test or APOB (hypercholesterolemia) Mutation Analysis? ❑Yes* ❑No

If YES, please select one of the following: ❑LDL-R DNA Sequencing Test **OR** ❑APOB Mutation Analysis

c. Does the patient have a drawn LDL-C level greater than or equal to 100 mg/dL in the last 6 months? ❑Yes ❑No

❑ Other ***(please specify)*****:** _____

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Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

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CONTINUATION OF THERAPY (PA RENEWAL)

Praluent (alirocumab)

NOTE: Form must be completed in its **entirety** for processing

Please select strength: ❑**75 mg** ❑**150 mg**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Will the patient need more than 6 syringes every 90 days? ❑Yes***** ❑No
   ****If YES***, please specify the requested quantity: _____ syringes every 90 days
4. **Standard Option Patient:** Would you like to participate in this program and switch the patient to Repatha? ***Select answer below:***
   ❑**Yes** ***(please select strength)***: ❑Repatha 140mg **OR** ❑Repatha 420mg
   ❑**No**: Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to Repatha?
   ❑**Yes** ***(specify result)***: _____
   ❑**No**: Is there a clinical reason for not trying Repatha? ❑Yes***** ❑No
   ****If YES***, please specify: _____
5. What is the patient's diagnosis?
   ❑Atherosclerotic cardiovascular disease (ASCVD) ❑Hypercholesterolemia ❑Hyperlipidemia
   ❑Heterozygous familial hypercholesterolemia (HeFH)
   ❑Homozygous familial hypercholesterolemia (HoFH)
   ❑Other ***(please specify)*****:** _____
6. Will the patient be assessed for adherence to the prescribed lipid lowering regimen? ❑Yes ❑No
7. Does the patient have an absolute LDL-C less than 100 mg/dL? ❑Yes ❑No*****
   ****If NO***, is there a percentage reduction of LDL-C level greater than or equal to 40%, compared to the level immediately prior to starting a PCSK9 inhibitor? ❑Yes ❑No
8. Will Praluent be used in combination with another *****Prior Authorization (PA) lipid lowering agent? ❑Yes***** ❑No
   ****If YES***, please specify the medication: _____
   ****PA Lipid Lowering Agents: Juxtapid (lomitapide), Leqvio (inclisiran), Nexletol (bempedoic acid), Nexlizet (bempedoic acid/ezetimibe), Repatha (evolocumab)***

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To ensure a quick and accurate response to your prior approval request, please **submit medical records (laboratory reports)** pertaining to the diagnosis only. Please do not send in medical records of other diagnoses in order to streamline the process. Please use this page as a **guideline** of what documentation is required to process the prior authorization request.

***For more efficient processing, please provide the page number of the documented information in the medical record**

Documentation Required for <u>INITIATION</u> of Therapy:

❑Inadequate treatment response to 3 months of at least **ONE** high intensity statin or intolerance or contraindication to statin therapy: **PAGE _____ of _____**

- High-Intensity Statins: Atorvastatin 40-80mg/day (Lipitor), Rosuvastatin 20-40mg/day (Crestor)

❑Drawn LDL-C level in the past 6 months **PAGE _____ of _____**