HIGHMARK

PRESCRIPTION DRUG
MEDICATION REQUEST FORM
FAX TO 1-866-240-8123

PCSK9 Inhibitors: Repatha® (evolocumab) & Praluent® (alirocumab)

Patient/Provider Information:

Subscriber ID Number			Group Number
Patient Name	Patient Telephone Number		Date of Birth
Patient Address	City	State	Zip Code
Physician Name	Phone		Fax
Physician Address	City	State	Zip Code
Suite / Building	Physician Signature		Date

Clinical Information:

Please specify the medication being requested: ☐Repatha Syringe 140mg/ml ☐Praluent Pen 75mg/ml ☐Repatha Sureclick 140mg/ml ☐Praluent Pen 150mg/ml ☐Repatha Pushtronex 420mg/3.5ml	**Requested quantity *per month*: _____**

Documentation of Medical Necessity:

1. Repatha or Praluent is being prescribed by (or in consultation with) a:
   ☐Cardiologist ☐Endocrinologist ☐Lipid Specialist ☐Other _____
2. Does the patient have homozygous familial hypercholesterolemia (HoFH)? ☐Yes ☐No
   If **YES**:
   a. Will the patient continue to receive concurrent lipid-lowering therapies for the treatment of HoFH?
      ☐Yes ☐No
   b. Please check all that apply:

☐Untreated LDL-C greater than 400 mg/dL ☐Untreated total cholesterol greater than 500 mg/dL ☐Genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus	☐There is evidence of heterozygous familial hypercholesterolemia in both of the patient's parents ☐ The patient had cutaneous or tendon xanthoma before 10 years of age

3. Does the patient have heterozygous familial hypercholesterolemia (HeFH)? ☐Yes ☐No
   a. If **YES**, please check all that apply:

☐Untreated LDL-C greater than or equal 190 mg/dL ☐Untreated LDL-C greater than or equal 160 mg/dL before 20 years of age ☐ Genetic confirmation of one mutant allele at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus	☐The patient experienced tendon corneal arcus prior to age 45 years, tendon xanthoma, tuberous xanthoma, or xanthelasma ☐WHO criteria/Dutch Lipid Clinical Network score greater than 8 points ☐ Familial hypercholesterolemia possibility of "definite" based on the Simon Broome register

4. Does the patient have atherosclerotic cardiovascular disease (ASCVD)? ☐Yes ☐No
   a. If **YES**, please check all that apply:
   ☐History of myocardial infarction (MI) ☐History of stroke or transient ischemic attack (TIA)
   ☐Acute Coronary syndrome (ACS) ☐Peripheral arterial disease (PAD)
   ☐Stable or unstable angina ☐Coronary or other arterial revascularization procedure

5. Has the patient experienced therapeutic failure to a maximally tolerated statin? ☐Yes ☐No

6. Is the patient **statin intolerant**? ☐Yes ☐No
   If **YES**: Please answer the following:
   a. Has the patient experienced statin-related rhabdomyolysis or skeletal-related muscle symptoms while receiving at least two separate trials of different statins? ☐Yes ☐No
   b. Please indicate if the patient has experienced any of the following during statin therapy:
      ☐ CK (Creatinine kinase) increase to 10 times upper limit of normal
      ☐ LFTs (Liver Function Tests) increase to 3 times upper limit of normal
      ☐ Hospitalization due to a statin-related adverse event such as rhabdomyolysis

7. Prior to the start of Repatha (evolocumab) or Praluent (alirocumab) therapy, did the patient have a coronary artery calcium or calcification (CAC) score greater than or equal to 300 Agatston units? ☐Yes ☐No

8. If this request is for Praluent (alirocumab), has the patient experienced therapeutic failure or intolerance to Repatha (evolocumab)? ☐Yes ☐No

9. Is the patient currently established on therapy with Repatha or Praluent? ☐Yes ☐No
   a. If **YES**:
   Please specify how long the patient has been on therapy: _____

10. Please provide the patient's **pretreatment** LDL-C level (prior to therapy with Repatha or Praluent):

    Pretreatment LDL-C: _____mg/dL Date of lipid panel: _____

11. If the patient is already established on therapy with Repatha or Praluent, please provide the patient's **current** LDL-C level (after therapy with Repatha or Praluent):

    Current LDL-C: _____mg/dL Date of lipid panel: _____

12. Please provide any additional information pertinent to this request: _____

    _____

    _____

The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
3. Please provide the physician address as it is required for physician notification.
4. Fax the **completed** form and all clinical documentation to **1-866-240-8123**