HIGHMARK

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

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

Patient Information:

Subscriber's ID Number			Subscriber's Group Number
Patient's Name		Phone	Date of Birth
Address	City	State	Zip Code

Provider Information:

Physician's Name	NPI	Phone	Fax
Address	City	State	Zip Code
Suite / Building	Physician's Signature		Date

Medication 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/3.5mll	**Requested quantity *per month*:** ______________

Clinical Criteria:

Please provide a diagnosis and/or ICD-10 code(s): ____

1. Repatha or Praluent is being prescribed by (or in consultation with) a:
   ☐Cardiologist ☐Endocrinologist ☐Lipid Specialist ☐Other ______________________
2. Does the patient have atherosclerotic cardiovascular disease (ASCVD)? ☐Yes ☐No
   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
3. Does the patient have homozygous familial hypercholesterolemia (HoFH)? ☐Yes ☐No
   If **YES**, 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

4. Does the patient have heterozygous familial hypercholesterolemia (HeFH)? ☐Yes ☐No
   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 ☐Familial hypercholesterolemia possibility of "definite" on the Make Early Diagnosis to Prevent Early Deaths (MEDPED) tool

5. Does the patient have primary hyperlipidemia that is not associated with ASCVD, HeFH, or HoFH?
   If **YES**:
   a. 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
6. Has the patient experienced therapeutic failure to a maximally tolerated statin? ☐Yes ☐No
7. 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
8. If this request is for Praluent (alirocumab), has the patient experienced therapeutic failure or intolerance to Repatha (evolocumab)? ☐Yes ☐No
9. 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: ____________________
10. Is the patient currently established on therapy with Repatha or Praluent? ☐Yes ☐No
    If **YES**:
    a. Please specify how long the patient has been on therapy: ___________________

    b. Please provide the patient's **current** LDL-C level (after therapy with Repatha or Praluent):

    Current LDL-C: ____________mg/dL Date of lipid panel: ____________________
11. Will the patient continue to receive concurrent lipid-lowering therapies?
    ☐Yes ☐No
12. Please provide any additional information for this request (e.g. previously tried medications, medical necessity rationale, etc.):

    ____

    ____

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**
   Or mail the form to: **Clinical Services,**
   120 Fifth Avenue, MC PAPHM-043B, Pittsburgh, PA 15222