UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

PCSK9 Inhibitors (Praluent, Leqvio, Repatha)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: *(All criteria must be met)).*

- ❑ Medication prescribed by, or in consultation with, a cardiologist, endocrinologist or ABCL (or equivalent) certified lipid specialist.
- ❑ Trial or patient intolerability of HMG-CoA reductase inhibitor ("statin") therapy in conjunction with Zetia (ezetimibe): at maximum FDA-approved dose to establish statin insufficiency.
    - Medication name and dosage: _____
- ❑ Intolerant or allergic to Zetia (ezetimibe) or clinical rationale for non-use:
    - Details: _____
- ❑ Cholesterol level before treatment:
    - LDL ≥ 70 mg/dL or non-HDL ≥ 100 mg/dL
      For secondary prevention of cardiovascular events in patients with Heterozygous Familial Hypercholesterolemia (FH), or Type 2 Diabetes, or two major risk factors as defined by current guidelines.
    - LDL ≥ 100 mg/dL or non-HDL ≥ 130 mg/dL
      For primary prevention of cardiovascular events in patients with Heterozygous FH or Type 2 Diabetes, or two major risk factors as defined by current guidelines
    - LDL ≥ 160 or non-HDL ≥ 190
      For patients with at least one risk factor as defined by current guidelines
- ❑ MUST be used in conjunction with:
    - HMG-CoA reductase inhibitor ("statin") therapy at maximum FDA-approved dose to establish statin insufficiency or at maximum dose tolerated by patient.
    - Zetia (ezetimibe)

Non-Preferred Product: *(Criteria above must also be met)*

- ❑ Trial and failure of preferred PCSK9 inhibitor, per Utah Medicaid's PDL, or prescriber must demonstrate medical necessity for non-preferred product.
  Details: _____ Chart Note Page #: _____

Re-authorization Criteria:

Updated letter with medical justification or updated chart notes demonstrating positive clinical response.

Initial Authorization: Up to three (3) months
Re-authorization: Up to one (1) year

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date