

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

Proprotein Convertase Subtilisin Kexin Type 9 Inhibitor Antibodies

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO 855-828-4992**

CRITERIA:

- Failure on HMG-CoA reductase inhibitor (“statin”) therapy: at maximum FDA-approved dose to establish statin insufficiency or at minimum FDA-approved dose to establish patient intolerability.
- Medication should be prescribed by, or in consultation with, an ABCL (or equivalent) certified lipid specialist.
- Cholesterol level before treatment:
 - LDL \geq 100 mg/dL or non-HDL \geq 130 mg/dL
For secondary prevention of cardiovascular events in patients with Heterozygous FH, or Type 2 Diabetes, or two major risk factors as defined by current guidelines
 - LDL \geq 130 mg/dL or non-HDL \geq 160 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 \geq 160 or non HDL \geq 190
For patients with at least one risk factor as defined by current guidelines

Initial Authorization: 1 year

Reauthorization: Letter from prescriber indicating drug effectiveness, duration 1 year