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 ≥ 100 mg/dL or non-HDL ≥ 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 ≥ 130 mg/dL or non-HDL ≥ 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 ≥ 160 or non HDL ≥ 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

01/19/2016

https://medicaid.utah.gov/pharmacy/