

**Montana Healthcare Programs Prior Authorization Request Form for Use of
PCSK-9 Inhibitors (Praluent/Repatha)**

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty (if applicable):	Prescriber Fax:	
Requested Drug/Dose/Directions:		

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ INITIATION OF THERAPY

1. Member must have *appropriate FDA-approved indication* for medication selected (please check):

Praluent:

- ☐ Heterozygous familial hypercholesterolemia (HeFH)
☐ Clinical atherosclerotic cardiovascular disease (ASCVD) i.e. heart attacks/strokes

Repatha:

- ☐ Heterozygous familial hypercholesterolemia (HeFH)
☐ Homozygous familial hypercholesterolemia (HoFH)
☐ Clinical atherosclerotic cardiovascular disease (ASCVD) i.e. heart attacks/strokes
☐ Primary hyperlipidemia

2. Initial baseline LDL level: _____ Date: _____
3. PCSK-9 inhibitor is being requested due to: ☐ Excessively High LDL levels ☐ Intolerance to statins
4. Treatment with at least two high intensity statins (i.e., atorvastatin/rosuvastatin) at maximum tolerated dose in combination with ezetimibe has been ineffective, contraindicated or not tolerated:
- First statin used/dose: _____ Statin Dates: _____ Ezetimibe dates: _____
 - LDL level after at least 12 weeks: _____
 - Reason for discontinuation: _____
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- Second statin used/dose: _____ Statin Dates: _____ Ezetimibe dates: _____
 - LDL level after at least 12 weeks: _____
 - Reason for discontinuation: _____

LIMITATIONS: Praluent: 2 doses/ month (either strength). **Repatha:** 140 mg = 2 doses/month. 420 mg = one dose/month.
Initial authorization will be granted for 12 weeks.

☐ CONTINUATION OF THERAPY-Attach lab work documenting positive response to therapy (i.e. reduction in LDL-C).

Reauthorization will be issued for 1 year.

Please complete form, including required attachments and fax to:
Drug Prior Authorization Unit at 1-800-294-1350