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

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>DOB:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Member ID:</td>
<td>Prescriber Phone:</td>
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<tr>
<td>Prescriber Name/Specialty (if applicable):</td>
<td>Prescriber Fax:</td>
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<td>Requested Drug/Dose/Directions:</td>
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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: ____________________________________________________________________

   - 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

01/2020