Mountain Pacific
INNOVATING BETTER HEALTH

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Montana Healthcare Programs Prior Authorization Request Form for Use of Leqvio® (inclisiran)

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 is 18 years of age or older: ☐ Yes ☐ No
2. Member must have appropriate U.S. Food and Drug Administration (FDA)-approved indication for medication (please check):
   - ☐ Heterozygous familial hypercholesterolemia (HeFH) and has a low-density lipoprotein (LDL)-cholesterol equal to or greater than 70mg/dL **OR**
   - ☐ Primary hyperlipidemia and has an LDL-cholesterol equal to or greater than 100mg/dL.
3. Medication is being prescribed by or in consultation with a cardiologist, endocrinologist or lipidologist: ☐ Yes ☐ No

   Action required: If not in a specialty clinic or written by a specialist, information on annual consult with an appropriate specialist is required.

   Name of specialist: _____ Contact date: _____
4. Member has LDL-cholesterol level equal to or greater than 70mg/dl for HeFH or 100mg/dL for primary hyperlipidemia: ☐ Yes ☐ No

   Please provide baseline LDL: _____ **Date:** _____

   Note: If LDL levels cannot be determined due to high triglycerides, direct LDL-C testing is required.
5. Member has trialed at least **two** high-intensity statins at maximum tolerated doses for at least 12 weeks:

   First statin used/dose: _____ Statin dates: _____

   Reason for discontinuation: _____

   Second statin used/dose: _____ Statin dates: _____

   Reason for discontinuation: _____
6. Member will continue receiving a maximally tolerated high intensity statin: ☐ Yes ☐ No

   Drug name/dose: _____

   If no, please indicate the reason: _____

7. Member has trialed ezetimibe for at least 12 weeks: ☐ Yes ☐ No

   Dates of use: _____ Reason for discontinuation: _____

8. Provider attests member will not take Leqvio® in combination with Juxtapid®, Repatha®, Praluent® or other PCSK9 medications: ☐ Yes ☐ No

LIMITATIONS:
Maximum dose allowed: 284mcg at initial fill and at 3 months, then 284mcg every 6 months after.

Initial authorization will be granted for 9 months.

☐ CONTINUATION OF THERAPY

1. Member has been adherent to Leqvio®: ☐ Yes ☐ No
2. Member has been adherent to statin at maximally tolerated dose: ☐ Yes ☐ No
3. Member has demonstrated positive clinical improvement (i.e. reduction in LDL-C) ☐ Yes ☐ No

   Action required: Please attach lab work.

4. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A – Prescriber is a specialist.
5. Provider attests member will not take Leqvio® in combination with Juxtapid®, Repatha®, Praluent® or other PCSK9 medications: ☐ Yes ☐ No

LIMITATIONS:
Maximum dose allowed: 284mcg every 6 months

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.

10/2023