Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Pharmacy Benefits Prior Authorization Help Desk
Prior Authorization (PA) PCSK9 Inhibitors (Praluent or Repatha)

KAISER PERMANENTE®

Instructions:

This form is used by participating providers for coverage of **PCSK9 Inhibitors (Praluent or Repatha) for heterozygous familial hypercholesterolemia (HeFH), homozygous familial hypercholesterolemia (HoFH), or Clinical ASCVD.** Please complete and fax this form back to Kaiser Permanente within 24 hours at fax: 1-866-331-2104. If you have any questions or concerns please call 1-866-331-2103. **Request will not be considered unless form is completely filled out.**

KP-MAS Formulary can be found at www.providers.kp.org/mas/formulary.html

A. Patient Information

Patient Name:	Kaiser ID (if available):
Patient Date of Birth:	Patient Phone Number:

B. Provider Information

Provider Name:	Provider Address:
Provider NPI:	Provider Phone Number:
Provider Fax Number:	Provider Specialty:

Please check the box that applies:
□Initial Request □ Continuation of Therapy Request
□ Standard Review (72 hours)
□ Expedited Review (24 hours): By checking this box, I certify that applying 72 hours standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Provider Signature_____

C. Pharmacy Information

Pharmacy Name:	NABP/NPI #:
Pharmacy Phone Number:	Pharmacy Fax Number:

D. Drug Information

Drug Name and Strength:	Quantity and Days Supply (PCSK9 inhibitors are limited to a 30 day supply per fill):
Directions (SIG):	Date Requested:

E. LENGTH OF AUTHORIZATION : 6 months

1. Is the prescriber a cardiologist, endocrinologist, or in consultation from a cardiologist?
☐ Yes, if consulted a cardiologist, provide name _____ and go to question 2
☐ No [If no, then no further questions required]

2. Please indicate age group for appropriate indication:
☐ 18-79 years old and being considered for treatment with Praluent (alirocumab) for heterozygous familial hypercholesterolemia (HeFH)
☐13-79 years old being considered for treatment with Repatha (evolocumab) for HeFH/Homozygous familial hypercholesterolemia (HoFH)
☐40-85 years old being considered for treatment with Repatha (evolocumab) for clinical ASCVD*
☐ None of the above [No further questions required]

** history of myocardial infarction, nonhemorrhagic stroke, or symptomatic peripheral artery disease, and additional characteristics that placed them at higher cardiovascular risk*

3. Please indicate the patient's diagnosis for taking PCSK9 inhibitor?
☐ Clinical ASCVD* - recommended for Repatha only [if yes, please go to question 5]
☐ Confirmed HeFH [if yes, please go to question 4]
☐ Confirmed HoFH (indicated for Repatha only) [if yes, please go to question 4]
☐ Suspected familial hypercholesterolemia given LDL ≥190 mg/dL [if yes, please go to question 4]

** ASCVD defined as:*

1. History of clinically evident cardiovascular disease as evidenced by <u>any</u> of the following: diagnosis of myocardial infarction, diagnosis of nonhemorrhagic stroke, or symptomatic peripheral artery disease (evidenced by intermittent claudication with ankle-brachial index <0.85, or peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease)

2. <u>At least 1 major risk factor</u> (type 1 or 2 diabetes, age ≥65 years, MI or non-hemorrhagic stroke within 6 months of screening, additional diagnosis of myocardial infarction or non-hemorrhagic stroke excluding qualifying MI or non-hemorrhagic stroke, current daily cigarette smoking, history of symptomatic PAD if eligible by MI or stroke history) or <u>at least 2 minor risk factors</u> (history of non-MI related coronary revascularization, residual coronary artery disease with ≥40% stenosis in ≥2 large vessels, most recent HDL-C <40 mg/dL for men and <50 mg/dL for women, most recent hsCRP >2.0 mg/L, most recent LDL-C ≥130 mg/dL or non-HDL-C ≥160 mg/dL, metabolic syndrome)

4. For patients with HeFH/HoFH only, does patient have documented LDL-C > 130 mg/dL in the last 90 days?

☐ If Yes, include LDL value and go to question 6 ☐ No [If no, then no further questions required]

LDL value: _____ date: _____

5. For patient with clinical ASCVD, does patient have documented LDL-C > 70 mg/dL in the last 90 days?

☐ If Yes, include LDL value and go to question 6 ☐ No [If no, then no further questions required]

LDL value: _____ date: _____

6. Has the patient had an adequate trial of high-dose, high-potency statin plus Zetia?

☐ If Yes, please go to question 10 ☐ No, please go to question 7

7. Is the patient currently taking the maximum tolerated dose of another statin for at least 90 days?

☐ If Yes, please go to question 10 ☐ No, please go to question 8

8. Does patient meet the following Statin Intolerance criteria? (Please check all that apply)

- ☐ Inability to tolerate at least 2 statins, with at least one started at the lowest starting daily dose ***AND***
  - ☐ Statin dose reduction attempted for resolution of muscle symptoms, abnormal biomarkers ***OR***
  - ☐ Muscle symptoms, abnormal biomarkers recur with low-intensity/lowest possible statin dose re-challenge ***OR***
  - ☐ Muscle symptoms, abnormal biomarkers recur with an adequate trial of hydrophilic statins – Pravastatin, Rosuvastatin
  - ☐ If Yes, please go to question 10 ☐ IF No, please go to question 9

9. Does patient have an absolute contraindication to statin or documented history of CPK elevation >10x ULN OR rhabdomyolysis attributed to a statin?

☐ If Yes, include documentation of lab results and go to question 10 ☐ No [If no, then no further questions required]

10. Has the member previously taken Praluent or Repatha?

☐ Yes, patient has previously taken Praluent 75mg. Provide dates and duration of therapy: _____

LDL-C pre-therapy/date: _____ LDL-C post-therapy/date: _____

Note: Praluent 75mg should only be continued beyond 8 weeks in presence of LDL-C decrease of greater than 30%. Praluent 150mg will only be approved if there has been a trial of Praluent 75mg for a minimum of 8 weeks with a LDL-C change of less than 30%. Please include lab results demonstrating LDL-C reduction pre and post therapy.

☐ Yes, patient has previously taken Praluent 150mg. Provide dates and duration of therapy: _____

LDL-C pre-therapy/date: _____ LDL-C post-therapy/date: _____

Note: Praluent 150 mg should only be continued beyond 8 weeks in presence of LDL-C decrease of greater than 30%.

☐ Yes, patient has previously taken Repatha 140mg. Provide dates and duration of therapy: _____

LDL-C pre-therapy/date: _____ LDL-C post-therapy/date: _____

Note: Repatha 140mg qty #3 for 28 day supply will only be approved for diagnosis of homozygous familial hypercholesterolemia (HoFH).
Repatha 140mg qty #2 for 28 day supply will only be approved for diagnosis of Clinical ASCVD OR suspected familial hypercholesterolemia OR heterozygous familial hypercholesterolemia (HeFH) if patient has failed treatment with Praluent 150mg or experienced an adverse effect to Praluent 75mg or 150mg. Repatha 140mg should only be continued beyond 8 weeks in presence of LDL-C decrease of greater than 30%.

☐ No, patient has never taken Praluent or Repatha.

Please complete section F and G

F. Additional Information – please provide any additional information that should be taken into consideration.

G. Prescriber Sign off

Prescriber Signature:	Date:
Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility	