OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

Drug Requested: **Kynamro®** (mipomersen)

DRUG INFORMATION: Complete information below. Authorization process will be delayed if incomplete.

Drug Form/Strength: ______________________________

Dosing Schedule: ______________________ **Length of Therapy**: ______________

Diagnosis: ______________________ ***ICD Code, if applicable***: ______________.

CLINICAL CRITERIA: ALL appropriate boxes must be checked to qualify or authorization process will be delayed.

- ❑ Patient must be ≥ 18 years old
- ❑ Prescribers must enroll in the Kynamro™ REMS program and complete the Prescriber Training Module and complete, sign, and submit the Prescriber Enrollment Form to the Kynamro™ REMS program.
- ❑ Patient has tried one (1) of the following in the past 6 months and is able to provide documentation presenting evidence of adherence to statin therapy for at least the last 90 consecutive days:

❑ Crestor® (rosuvastatin) 40mg/day	❑ Lipitor® (atorvastatin) 80mg/day	❑ Zocor® (simvastatin) 40mg/day
❑ Pravachol® (pravastatin) 80mg/day	❑ Mevacor® (lovastatin) 80mg/day	❑ Lescol® (Fluvastatin) 80mg/day
❑ Livalo® (pitavastatin) 4mg/day		

- ❑ Patient has undergone at least one LDL apheresis procedure

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: ______________________________

Member Optima #: ______________________ Date of Birth: ______________

Prescriber Name: ______________________________

Prescriber Signature: ______________________ Date: ______________

Office Contact Name: ______________________________

Phone Number: ______________________ Fax Number: ______________

DEA OR NPI #: ______________________________

***Approved by Pharmacy and Therapeutics Committee:** 10/17/2013
REVISED/UPDATED: ~~11/20/2013; 11/2/2014; 5/22/2015; 12/28/2015; 12/19/2016;~~ **9/21/2017**;