

# 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:**                      **Repatha™** (evolocumab)

**DRUG INFORMATION:** Complete information below or authorization process will be delayed.

**Drug Form/Strength:** \_\_\_\_\_

**Dosing Schedule:** \_\_\_\_\_                      **Length of Therapy:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_                      **ICD Code, if applicable:** \_\_\_\_\_

**CLINICAL CRITERIA:** ALL information below **must** be checked to qualify or authorization process will be delayed. Chart notes and any lab results **MUST** be submitted with this request to include a baseline lipid panel **AND** panel post statin therapy.

**Initial Criteria - approval is for 3 months.**

- Diagnoses: (select one below)**
  - Clinical Atherosclerotic Cardiovascular Disease
  - OR**
  - Heterozygous familial hypercholesterolemia (HeFH) **OR** homozygous familial hypercholesterolemia by (HoFH) one of the following:
    - Genetic confirmation of a mutation in the LDL receptor, ApoB-100, or PCSK9, confirmed by clinical criteria (confirmation of FH using either Simon Broome or WHO/Dutch Lipid Network criteria) **OR**
    - Untreated/pre-treatment LDL  $\geq$  190 mg/dl in adult with presence of tendon xanthomas in patient, first degree relative or second degree relative
  - AND**
  - Prescribed by, or in consultation with a cardiologist, endocrinologist or lipid specialist
  - Adjunct to low-fat diet and exercise
  - No labeled contraindications to PCSK9 therapy

**AND two (2) of the following:**

<input type="checkbox"/> <b>High-Intensity Statin Candidate</b>	<input type="checkbox"/> <b>Moderate-Intensity Statin Candidate</b>	<input type="checkbox"/> <b>Intolerance to Statins</b>	<input type="checkbox"/> <b>Contraindication to Statins</b>
Patient has received at least 3 months of therapy with: <ul style="list-style-type: none"> <li>▪ High-intensity statin therapy</li> <li style="text-align: center;"><b>AND</b></li> <li>▪ Add-on therapy with ezetimibe (Zetia) or bile acid sequestrants to the maximum tolerable dose of statin</li> <li style="text-align: center;"><b>AND</b></li> </ul> Failure to reach target LDL-C (70 mg/dl for patients with clinical ASCVD and 100 mg/dl for patients with HeFH and no history of clinical ASCVD) <ul style="list-style-type: none"> <li style="text-align: center;"><b>AND</b></li> </ul> Statin therapy will be continued with PCSK9 therapy	Patient has intolerance or contraindications to high-intensity statin therapy <ul style="list-style-type: none"> <li style="text-align: center;"><b>AND</b></li> </ul> Patient has received at least 3 months of therapy with moderate-intensity statin therapy: <ul style="list-style-type: none"> <li style="text-align: center;"><b>AND</b></li> </ul> Add-on therapy with ezetimibe (Zetia) or bile acid sequestrants to the maximum tolerable dose of statin or Vytorin <ul style="list-style-type: none"> <li style="text-align: center;"><b>AND</b></li> </ul> Failure to reach target LDL-C (70 mg/dl for patients with clinical ASCVD and 100 mg/dl for patients with HeFH and no history of clinical ASCVD) <ul style="list-style-type: none"> <li style="text-align: center;"><b>AND</b></li> </ul> Statin therapy will be continued with PCSK9 therapy	Patient experienced one of the following symptoms to at least <b>two</b> different statins <ul style="list-style-type: none"> <li>▪ Myalgia (muscle symptoms without CK elevations)</li> <li>▪ Myositis (muscle symptoms with CK elevations &lt; 10 times ULN)</li> <li style="text-align: center;"><b>AND</b></li> </ul> Reinitiating of statin therapy must have been attempted and failed	Patient has a labeled contraindication to all statins as documented in medical records <ul style="list-style-type: none"> <li style="text-align: center;"><b>OR</b></li> </ul> Patient has experienced: <ul style="list-style-type: none"> <li>▪ Rhabdomyolysis or muscle symptoms with CK elevations <math>\geq</math> 10 times ULN</li> </ul>

*(continued on next page)*

**Renewal criteria – approved for 12 months. Requests must include all of the following information:**

- Patient has been compliant on therapy and is continuing a low-fat diet and exercise regimen
- Lipid panel showing further reduction in LDL cholesterol compared to the labs prior to initiating a PCSK9 inhibitor
- Patient does not have any contraindications to therapy
- Continued adherence to maximally tolerated statin dose established prior to the initial PCSK9 inhibitor approval

**\*\*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: 9/17/15

REVISED/UPDATED: 9/28/2015; 10/14/2015; 10/19/2015; 11/4/2015; 11/10/2015; 11/19/2015; 12/29/2015; 12/19/2016; 9/22/2017