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: **Praluent**® (alirocumab) **Injection**

DRUG INFORMATION: ***Complete all 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 ensure authorization process will NOT 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.

- Must be prescribed or in consultation with one of the following:

❑ Cardiologist	❑ Endocrinologist	❑ Lipid Specialist

AND

❑ Adjunct to low-fat diet and exercise

Diagnoses: (select one below)

❑ ***Atherosclerotic Cardiovascular Disease: Select if the patient has Atherosclerotic cardiovascular disease (ASCVD) confirmed by the following:***

- ❑ Acute Coronary Syndrome
- ❑ History of myocardial infarction
- ❑ Stable or unstable angina
- ❑ Peripheral arterial disease presumed to be of atherosclerotic origin
- ❑ Coronary or arterial revascularization
- ❑ Stroke
- ❑ Transient ischemic attack

Please note: Chart documentation of the above is required to be submitted along with this request form.*

❑ ***Heterozygous familial hypercholesterolemia (HeFH): Select if the patient has heterozygous familial hypercholesterolemia (HeFH) as confirmed by the following:***

- ❑ Untreated/pre-treatment LDL cholesterol (LDL-C) ≥ 190mg/dL in an adult or ≥ 155mg/dL in a child less than 16 years of age

AND (*ONE* of the following)

- ❑ Family history of myocardial infarction in first-degree relative less than 60 years of age
- ❑ Family history of myocardial infarction in second-degree relative less than 50 years of age
- ❑ Submission of medical records (e.g., chart notes, laboratory values) documenting LDL-C > 190mg/dL in first or second degree relative

OR (*ONE* of the following)

Select if there is submission of medical records (e.g., chart notes, laboratory values documenting the following:

- ❑ Genetic confirmation of functional mutation in the LDL receptor, Apo-B, or PCSK9 gene adaptor protein 1 (i.e., LDLRAP1 or ARH)
- ❑ Tendinous xanthomata

Please note: Chart documentation of the above is required to be submitted along with this request form.*

❑ Other diagnosis: _____

ICD-10 Code(s) plus description: _____

❑ Other diagnosis: _____

ICD-10 Code(s) plus description: _____

FOR ALL DIAGNOSIS: Skip to Section B IF patient is unable to tolerate statin therapy. *Chart notes or labs are REQUIRED for review*

A. Please select which statin therapy the patient has received for at least 12 consecutive weeks and will continue to receive at the maximally tolerated dose***:***

❑ High-intensity statin therapy

❑ Moderate-intensity statin therapy (patient unable to tolerate high intensity therapy)

❑ Low intensity statin therapy (patient unable to tolerate moderate intensity therapy)

Select ONE of the following LDL-C values while on maximally tolerated lipid-lowering therapy within the last 120 days:

❑ LDL-C greater than or equal to 100 mg/dL with ASCVD

❑ LDL-C greater than or equal to 130 mg/dL without ASCVD

❑ LDL-C between 70 and 99 mg/dL with ASCVD **AND** 12 consecutive weeks of ezetimibe (Zetia®) therapy as an adjunct to maximally tolerated statin therapy

❑ LDL-C between 100 mg/dL and 129 mg/dL without ASCVD **AND** 12 consecutive weeks of ezetimibe (Zetia®) therapy as an adjunct to maximally tolerated statin therapy

Please document: the LDL levels below (Labs MUST be attached or authorization will be delayed)

LDL baseline: _____ LDL post-treatment: _____

B. Select below if the patient is unable to tolerate low, moderate, and high intensity statin therapy as evidenced by one of the following intolerable and persistent symptoms to TWO different statins (i.e., more than 2 weeks): documentation MUST be provided and claims will be verified.

Drug Name: _____ Strength: _____ Date started: _____

Drug Name: _____ Strength: _____ Date started: _____

❑ Myalgia (muscle symptoms without CK elevations)

OR

❑ Myositis (muscle symptoms with CK elevations < 10 times upper limit of normal)

AND

❑ Reinitiating of statin therapy must have been attempted and failed

OR

❑ Patient has a labeled contraindication to ALL statins as documented in medical records and/or has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations > 10 times upper limit of normal

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 has been submitted:

LDL-C baseline: _____ LDL-C post-Praluent® treatment: _____

❑ Patient does not have any contraindications to therapy

❑ Continued adherence to maximally tolerated statin dose established prior to PCSK9 inhibitor approval unless patient has documented inability to take statins

❑ Patient is continuing a low-fat diet and exercise regimen

***Medication being provided by a Specialty Pharmacy* - PropriumRx**

(signature must be submitted with this form; information on next page)

*****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**: 9/17/2015
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; 8/16/2017.~~ **6/28/2018**