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)

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.

- ❑ ***Patient has documented trial and failure with Repatha***
- ❑ ***Diagnoses: (select one below)***
  - ❑ Clinical Atherosclerotic Cardiovascular Disease

    OR
  - ❑ Heterozygous familial hypercholesterolemia (HeFH)
    - ❑ 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≥ 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: ❑ Cardiologist **OR** ❑ Endocrinologist **OR** ❑ Lipid Specialist
- ❑ Adjunct to low-fat diet and exercise
- ❑ No labeled contraindications to PCSK9 therapy

AND *two (2)* of the following:

❑ High-Intensity Statin Candidate	❑ Moderate-Intensity Statin Candidate	❑ Intolerance to Statins	❑ Contraindication to Statins
Patient has received at least 3 months of therapy with: ▪ High-intensity statin therapy **AND** ▪ Add-on therapy with ezetimibe (Zetia) or bile acid sequestrants to the maximum tolerable dose of statin **AND** 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) **AND** Statin therapy will be continued with PCSK9 therapy	Patient has intolerance or contraindications to high-intensity statin therapy **AND** Patient has received at least 3 months of therapy with moderate-intensity statin therapy: **AND** Add-on therapy with ezetimibe (Zetia) or bile acid sequestrants to the maximum tolerable dose of statin or Vytorin **AND** 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) **AND** Statin therapy will be continued with PCSK9 therapy	Patient experienced one of the following symptoms to at least *two* different statins ▪ Myalgia (muscle symptoms without CK elevations) ▪ Myositis (muscle symptoms with CK elevations < 10 times ULN) **AND** Reinitiating of statin therapy must have been attempted and failed	Patient has a labeled contraindication to all statins as documented in medical records **OR** Patient has experienced: ▪ Rhabdomyolysis or muscle symptoms with CK elevations ≥ 10 times ULN

(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**: 9/17/2015
REVISED/UPDATED: ~~9/28/2015; 10/14/2015; 10/19/2015; 11/4/2015; 11/10/2015; 11/19/2015; 12/28/2015; 12/19/2016;~~ **8/16/2017**