Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Praluent® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Clinical atherosclerotic cardiovascular disease (ASCVD)
❑ Heterozygous familial hypercholesterolemia (HeFH)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Does the patient have a documented trial and failure with Repatha? ❑ **Yes** ❑ **No**

Select if Praluent is prescribed by or in consultation with one of the following specialists:
- ❑ Cardiologist
- ❑ Endocrinologist
- ❑ Lipid specialist

Is Praluent being used as an adjunct to a low-fat diet and exercise? ❑ **Yes** ❑ **No**

Does the patient have any labeled contraindications to PCSK9 therapy? ❑ **Yes** ❑ **No**

Select if the patient has received at least 3 months therapy with the following:
- ❑ High-intensity statin therapy
- ❑ Add-on therapy with ezetimibe (Zetia) or bile acid sequestrants to the maximum tolerable dose of statin

Has the patient failed to reach target LDL-C (70 mg/dL for patients with clinical ASCVD and 100 mg/dL for patient with HeFH and no history of clinical ASVCD)? ❑ **Yes** ❑ **No**

Chart notes and any lab results MUST be submitted with this request to include a baseline lipid panel AND panel post statin therapy

Will statin therapy be continued with PCSK9 therapy? ❑ **Yes** ❑ **No**

Select if the patient has experienced the following symptoms to at least two different statins:
- ❑ Myalgia (muscle symptoms without CK elevations)
- ❑ Myositis (muscle symptoms with CK elevations less than 10 times [ULN])

Have re-initiation of statin therapy been attempted and failed? ❑ **Yes** ❑ **No**

Does the patient have a labeled contraindication to all statins as documented in medical records? ❑ **Yes** ❑ **No**

Has the patient experienced rhabdomyolysis or muscle symptoms with CK elevations greater than or equal to 10 times upper limit of normal (ULN)? ❑ **Yes** ❑ **No**

Praluent® Prior Authorization Request Form (Page 2 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

For heterozygous familial hypercholesterolemia (HeFH), also answer the following:

Does the patient have 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)? ❑ **Yes** ❑ **No**

Is there presence of tendinous xanthomas in the patient, first degree relative or second degree relative? ❑ **Yes** ❑ **No**

Does the patient have untreated/pre-treatment LDL greater than or equal to 190 mg/dL? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following questions:

Has the patient been compliant on therapy? ❑ **Yes** ❑ **No**

Is the patient continuing on a low-fat diet and exercise regimen? ❑ **Yes** ❑ **No**

Has the patient's lipid panel shown further reduction in LDL cholesterol compared to the labs prior to initiating a PCSK9 inhibitor? ❑ **Yes** ❑ **No**

Chart notes and any lab results MUST be submitted with this request to include a baseline lipid panel AND panel post statin therapy

Does the patient have any contraindications to therapy? ❑ **Yes** ❑ **No**

Does the patient continue to be adherent to maximally tolerated statin doses established prior to the initial PCSK9 inhibitor approval? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

Previous therapies failed and/or therapies currently used in combination with the requested medication (*List ALL medications tried or authorization process will be delayed)*:_____

_____

_____

Is the prescribed dose higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert)? ❑ **Yes** ❑ **No**

If **Yes**, please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature).

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

_____

_____

****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.

Prescriber Signature: _____ **Date:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.