

**Repatha<sup>®</sup> 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:
<input type="checkbox"/> Check if requesting <b>brand</b>	Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>		

Clinical Information (required)
---------------------------------

**Select the diagnosis below:**

Clinical atherosclerotic cardiovascular disease (ASVCD)

Heterozygous familial hypercholesterolemia (HeFH)

Homozygous familial hypercholesterolemia (HoFH)

Other diagnosis: \_\_\_\_\_ ICD-10 Code(s): \_\_\_\_\_

**Clinical information:**

Is Repatha prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist?  Yes  No

Will Repatha be used as an adjunct to low-fat diet and exercise?  Yes  No

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

Select if the patient has had at least 3 months of 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

**For heterozygous familial hypercholesterolemia (HeFH) or homozygous familial hypercholesterolemia (HoFH), 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

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

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

**Repatha<sup>®</sup> Prior Authorization Request Form (Page 2 of 2)**  
DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

**Reauthorization:**

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

Has the patient been compliant on therapy and is continuing a low-fat diet and exercise regimen?  Yes  No

Has 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.