SENTARA COMMUNITY PLAN
(MEDICAID)

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. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Lipotropics, Other (Non-Preferred)

Drug Requested: (Select drug below)

❑ **Leqvio®** (inclisiran)	❑ **Praluent®** (alirocumab)
❑ **Repatha®** (evolocumab)	

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Specialty: Is the drug prescribed by or in consultation with a specialist?

❑ Cardiologists	❑ Lipidologists
❑ Endocrinologists	❑ Other:

(Continued on next page)

1. For what indications the drug is being prescribed? Check all that apply:
   - ❑ To reduce the risk of myocardial infarction, stroke, and coronary revascularization in adults with established cardiovascular disease
   - ❑ As an adjunct to diet, alone or in combination with other lipid-lowering therapies (e.g., statins, ezetimibe), for treatment of adults with primary hyperlipidemia (including heterozygous familial hypercholesterolemia (HeFH)) to reduce low-density lipoprotein cholesterol (LDL-C)
   - ❑ The member has had prior treatment history with highest available dose or maximally-tolerated dose of high intensity statin (atorvastatin or rosuvastatin) **and** ezetimibe for at least three continuous months with failure to reach target LDL-C **and** is in one of the three groups identified by NLA (i.e., extremely high risk ASCVD members with LDL-C ≥ 70mg/dL, very high risk atherosclerotic cardiovascular disease (ASCVD) member with LDL-C ≥ 100mg/dL, and high risk members with LDL-C ≥ 130mg/dL
   - ❑ Other: _____
2. Member is not able to use a maximum dose of atorvastatin or rosuvastatin due to muscle symptoms; documentation of a causal relationship must be established between statin use and muscle symptoms. Documentation must demonstrate that the member experienced pain, tenderness, stiffness, cramping, weakness, and/or fatigue and all of the following:
   a. Muscle symptoms resolved after discontinuation of statin;

      AND

   b. Muscle symptoms occurred when re-challenged at a lower dose of the same statin;

      AND

   c. Muscle symptoms occurred after switching to an alternative statin;

      AND

   d. Documentation ruling out non-statin causes of muscle symptoms (e.g., hypothyroidism, reduced renal function, reduced hepatic function, rheumatologic disorders, such as polymyalgia rheumatica, steroid myopathy, vitamin D deficiency, or primary muscle disease);

      OR

   e. Member has been diagnosed with statin-induced rhabdomyolysis

      ❑ Yes ❑ No

      If YES to any, give details:

      _____

      _____

      _____

      _____

3. Is this request for a new start or continuation of therapy? (If **New Start**, go to diagnosis section.)

   ❑ New Start ❑ Continuation

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Diagnosis and Lab Values for Homozygous Familial Hypercholesterolemia (HOFH)

4. Has genetic testing confirmed the presence of 2 mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus?

   ACTION REQUIRED: If YES, please attach a copy of genetic testing result.

   ❑ Yes ❑ No

5. Has the diagnosis of HoFH been confirmed by **ANY** of the following?

   ACTION REQUIRED: Please indicate below and provide a copy of the laboratory report with LDL-C level at time of diagnosis and other documentation supporting the presence of xanthoma or family history of HoFH (e.g., chart notes, medical records).

   - ❑ Untreated LDL-C > 500mg/dL **AND** cutaneous or tendon xanthoma before age 10 years
   - ❑ Untreated LDL-C > 500mg/dL **AND** untreated elevated LDL-C levels consistent with heterozygous familial hypercholesterolemia in both parents
   - ❑ Treated LDL-C ≥ 300mg/dL **AND** cutaneous or tendon xanthoma before age 10 years
   - ❑ Treated LDL-C ≥ 300mg/dL **AND** untreated elevated LDL-C levels consistent with heterozygous familial hypercholesterolemia in both parents
   - ❑ None of the above

6. Is age ≥ 13 years if diagnosed with homozygous familial hypercholesterolemia (HoFH)?

   ❑ Yes ❑ No

Diagnosis and Lab Values for Cardiovascular Event Risk Reduction

7. Does member have a history of clinical atherosclerotic cardiovascular disease (ASCVD) or a cardiovascular event listed below?

   ❑ Yes ❑ No

   - ❑ Acute coronary syndromes
   - ❑ Myocardial infarction
   - ❑ Stable or unstable angina
   - ❑ Stroke of presumed atherosclerotic origin
   - ❑ Transient ischemic attack (TIA)
   - ❑ Coronary or other arterial revascularization procedure (e.g., percutaneous transluminal coronary angioplasty (PTCA), coronary artery bypass graft (CABG))
   - ❑ Peripheral arterial disease of presumed atherosclerotic origin
   - ❑ Findings from computerized tomography (CT) angiogram or catheterization consistent with clinical ASCVD

8. What is the member's pre-treatment LDL-C level (i.e., prior to starting PCSK9 inhibitor therapy)?

   _____mg/dL (please attach laboratory results)

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Diagnosis and Lab Values for Heterozygous Familial Hypercholesterolemia (HEFH)

9. Does member have a **definite** diagnosis of heterozygous familial hypercholesterolemia (HeFH) as defined by the Dutch Lipid Clinical Network criteria (total score greater than 8)?

   ACTION REQUIRED: If **YES**, please provide a copy of the lab report with LDL-C level at time of diagnosis and other documentation supporting clinical/family history and/or physical findings (e.g., chart notes, medical records).

   ❑ Yes ❑ No

10. Does member have a definite diagnosis of HeFH as defined by Simon Broome diagnostic criteria?

    ❑ Yes ❑ No

Reauthorization Approval

11. Was this drug previously authorized for this member and are they stable on the medication?

    ❑ Yes ❑ No

12. How long has the member been receiving treatment with these medications?
    - ❑ 3 to 5 months (or first renewal request after initial authorization)
    - ❑ 6 months or more (or second and subsequent renewal requests)

13. Has the member achieved at least a 30% reduction in LDL-C since the beginning of treatment? (If Yes, please attach clinical notes and laboratory results that support reduction in LDL-C after initiation of therapy.)

    ❑ Yes ❑ No

14. Does the member continue to benefit from treatment as measured by either continued decrease in LDL-C levels or maintenance of optimum of LDL-C levels? (If Yes, please attach clinical notes and laboratory results that support continued benefit of Leqvio®, Praluent® or Repatha® therapy.)

    ❑ Yes ❑ No

15. Member is not able to use a maximum dose of atorvastatin or rosuvastatin due to muscle symptoms; documentation of a causal relationship must be established between statin use and muscle symptoms. Documentation must demonstrate that the member experienced pain, tenderness, stiffness, cramping, weakness, and/or fatigue. (Please provide documentation/chart notes)

    ❑ Yes ❑ No

Medication being provided by Specialty Pharmacy - PropriumRx

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.