FUTURE SCRIPTS Secure

Please complete ALL information below and fax your request to 1-888-671-5285

Repatha® Coverage Determination Request Form (Page 1 of 2)

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

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type(s) of Coverage Determination Requested:

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

❑ **Quantity Limit**- Request is for an exception to the plan's quantity limit.

Quantity per DAY requested? _____

Select the diagnosis below:

❑ Atherosclerotic cardiovascular disease (ASCVD)

❑ Homozygous familial hypercholesterolemia (HoFH)

❑ Hyperlipidemia

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is there documentation that the patient has an LDL-C 70mg/dL or greater after a minimum 8-week trial of at least moderate-intensity statin therapy? ❑ **Yes** ❑ **No**

Select if the patient has an inability to tolerate statin therapy as documented by the following:

- ❑ Rhabdomyolysis or symptoms with CK (creatine kinase) exceeding 10 times ULN (upper limit of normal)
- ❑ Myalgia (no CK elevations) with TWO statins
- ❑ Myositis (CK less than 10 times ULN) with TWO statins
- ❑ Hepatotoxicity from statin use (increased AST/ALT exceeding 3 times ULN)
- ❑ Liver disease documented by Child Pugh A or worse
- ❑ Liver disease documented by AST/ALT exceeding 3 times ULN for at least 6 weeks

For atherosclerotic cardiovascular disease (ASCVD), also answer the following:

Select if the patient's diagnosis is confirmed by of the following:

- ❑ Stress test
- ❑ Angiography
- ❑ Atherosclerotic event (e.g., MI, angina, stroke, claudication, carotid stenosis)
- ❑ Arterial intervention for atherosclerotic disease (e.g., coronary, peripheral, carotid)

Reauthorization:

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

Select if there is documentation of sustained reduction in LDL-C from baseline with the following:

❑ 25% reduction of LDL-C from baseline

❑ Sustained LDL-C below 70mg/dL

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Quantity Limit Requests:

Is there a high risk of significant adverse clinical outcome with medication change or dosage change? ❑ **Yes** ❑ **No**

Is the requested quantity and dose within FDA approved maximum dosing limits or supported by peer-reviewed medical literature, accepted standards of medical practice and/or medical compendia? ❑ **Yes** ❑ **No**

If **yes,** please specify:_____

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.