



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

### Praluent® Prior Authorization Request Form (Page 1 of 3)

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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:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)	
<b>Select the diagnosis below:</b>	
<input type="checkbox"/> Primary hyperlipidemia	
<input type="checkbox"/> Atherosclerotic cardiovascular disease (ASCVD)	
<input type="checkbox"/> Heterozygous familial hypercholesterolemia (HeFH)	
<input type="checkbox"/> Secondary prevention of cardiovascular events in patients with ASCVD	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	

**Clinical Information:**

Select if the patient has heterozygous familial hypercholesterolemia (HeFH) as confirmed by the following:

- Untreated/pre-treatment LDL-cholesterol (LDL-C) > 190 mg/dL in an adult or > 155 mg/dL in a child less than 16 years of age
- Family history of myocardial infarction in first-degree relative less than 60 years of age
- Family history of myocardial infarction in second-degree relative less than 50 years of age
- Family history of LDL-C > 190 mg/dL in first- or second-degree relative
- Family history of familial hypercholesterolemia in first- or second-degree relative
- Family history of tendinous xanthomata and/or arcus cornealis in first- or second-degree relative

Select if there is submission of medical records (e.g., chart notes, laboratory values) documenting the following:\*

- Functional mutation in the LDL receptor, ApoB, or PCSK9 gene
- Tendinous xanthomata
- Arcus cornealis before age 45

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

Select if the patient has atherosclerotic cardiovascular disease (ASCVD) confirmed by the following:

- Acute coronary syndromes
- History of myocardial infarction
- Stable or unstable angina
- Peripheral arterial disease presumed to be of atherosclerotic origin
- Coronary or arterial revascularization
- Stroke
- Transient ischemic attack

Has the patient been receiving at least 12 consecutive weeks of **high-intensity** statin therapy (i.e., atorvastatin 40-80 mg, Crestor [rosuvastatin] 20-40 mg)?  Yes  No

Will the patient continue to receive a **high-intensity** statin at maximally tolerated dose?  Yes  No

Select if the patient is unable to tolerate **high-intensity** statin therapy as evidenced by one of the following intolerable and persistent (i.e., more than 2 weeks) symptoms:

- Myalgia (muscle symptoms without CK elevations)
- Myositis (muscle symptoms with CK elevations less than 10 times the upper limit of normal [ULN])

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Has the patient been receiving at least 12 consecutive weeks of **moderate-intensity** statin therapy (i.e., atorvastatin 10-20 mg, Crestor [rosuvastatin] 5-10 mg, simvastatin 20-40 mg, pravastatin 40-80 mg, lovastatin 40 mg, Lescol XL [fluvastatin XL] 80 mg, fluvastatin 40 mg twice daily, or Livalo [pitavastatin] 2-4 mg)?  **Yes**  **No**

Will the patient continue to receive a **moderate-intensity** statin at maximally tolerated dose?  **Yes**  **No**

Has the patient been receiving at least 12 consecutive weeks of **low-intensity** statin therapy (i.e., simvastatin 10 mg, pravastatin 10-20mg, lovastatin 20mg, fluvastatin 20-40mg, Livalo [pitavastatin] 1 mg)?  **Yes**  **No**

Will the patient continue to receive a **low-intensity** statin at maximally tolerated dose?  **Yes**  **No**

Select if the patient is unable to tolerate **low-**, **moderate-**, and **high-intensity** statin therapy as evidenced by one of the following intolerable and persistent (i.e., more than 2 weeks) symptoms for low-, moderate-, and high-intensity statins:

- Myalgia (muscle symptoms without CK elevations)
- Myositis (muscle symptoms with CK elevations less than 10 times the upper limit of normal [ULN])

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 statin treatment with CK elevations > 10 times ULN?  **Yes**  **No**

Select if there is submission of medical records (e.g., laboratory values) documenting the following LDL-C values while on maximally tolerated lipid-lowering therapy **within the last 120 days**.\*

- LDL-C between 70 mg/dL and 99 mg/dL **with** ASCVD
- LDL-C ≥100 mg/dL **with** ASCVD
- LDL-C between 100 mg/dL and 129 mg/dL **without** ASCVD
- LDL-C ≥130 mg/dL **without** ASCVD

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

Has the patient been receiving at least 12 consecutive weeks of ezetimibe (Zetia) therapy as adjunct to maximally tolerated statin therapy?  **Yes**  **No**

If "no" to the above question, does the patient have a history of **contraindication or intolerance** to ezetimibe?  **Yes**  **No**

Select if Praluent is prescribed by one of the following specialists:

- Cardiologist
- Endocrinologist
- Lipid specialist

Does the prescriber attest that the information provided is true and accurate to the best of their knowledge and they understand that OptumRx may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided?  **Yes**  **No**

**Reauthorization:**

Does the patient continue to receive other lipid-lowering therapy (e.g., statins, ezetimibe) at the maximally tolerated dose, unless patient has a documented inability to take these medications?  **Yes**  **No**

Select if Praluent is prescribed by one of the following specialists:

- Cardiologist
- Endocrinologist
- Lipid specialist

Will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has had a reduction in LDL-C levels while on PCSK9 therapy?\*  **Yes**  **No**

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

Does the prescriber attest that the information provided is true and accurate to the best of their knowledge and they understand that OptumRx may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided?  **Yes**  **No**

**Quantity Limit Requests:**

What is the quantity requested per MONTH? \_\_\_\_\_

**What is the reason for exceeding the plan limitations?**

- Titration or loading dose purposes
- Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- Requested strength/dose is not commercially available
- Other: \_\_\_\_\_



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

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Please note: This request may be denied unless all required information is received.