FUTURE SCRIPTS

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

Praluent® & Repatha® Prior Authorization Request Form

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 **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Atherosclerotic cardiovascular disease
- ❑ Homozygous familial hypercholesterolemia (Repatha only)
- ❑ Hyperlipidemia
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Does the patient have LDL-C 70 mg/dL or greater after a minimum 8-week trial of at least moderate-intensity statin therapy?* ❑ **Yes** ❑ **No**

**Please note: Moderate intensity statins are defined as lowering LDL-C by approximately 30% to less than 50% (Atorvastatin 10 or 20 mg daily, fluvastatin XL 80 mg daily, fluvastatin 40 mg twice daily, lovastatin 40mg daily, pitavastatin 2 to 4 mg daily, pravastatin 40 mg or 80 mg daily, rosuvastatin 5 or 10 mg daily, simvastatin 20 to 40 mg daily)*

Does the patient have an inability to tolerate statin therapy as documented by having had rhabdomyolysis or symptoms with creatine kinase (CK) exceeding 10 times the upper limit of normal (ULN) on **any** statin? ❑ **Yes** ❑ **No**

Select if the patient has had an inability to tolerate statin therapy with **TWO** statins as documented by **ONE** of the following:

- ❑ Myalgia (no CK elevation)
- ❑ Myositis (CK less than 10 times ULN)
- ❑ Hepatotoxicity from statin use(increased AST/ALT exceeding 3 times ULN)
- ❑ Liver disease documented by Child Pugh A or worse OR AST/ALT exceeding 3 times ULN for at least 6 weeks

For atherosclerotic cardiovascular disease, also answer the following:

Is the patient diagnosed by either stress test, angiography, atherosclerotic event (e.g., MI, angina, stroke, claudication, carotid stenosis) or arterial intervention for atherosclerotic disease (e.g. coronary, peripheral, carotid)? ❑ **Yes** ❑ **No**

Continuation:

Has the patient had a sustained reduction in LDL-C of at least 25% since initiation of the requested medication? ❑ **Yes** ❑ **No**

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.