Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

PCSK9 Inhibitors (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of PCSK9 Inhibitors (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Praluent (alirocumab) Repatha (evolocumab)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question. Requests for PCSK9 Inhibitors will only be accepted by fax with the appropriate medical records and lab results. Requests will not be taken over the phone.

1. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 4.]

2. Has treatment with this medication resulted in a reduction in LDL from baseline? Y N

   NOTE: Results of fasting lipid profile within the past 3 months must be submitted with renewal requests.

   [If no, then no further questions.]

3. Is the patient compliant with therapy? Y N

   NOTE: Pharmacy claim history will be reviewed to confirm refills.

   [No further questions.]

4. Is the patient unable to tolerate statins? Y N

   NOTE: Medical records must be submitted supporting that skeletal muscle related symptoms occurred while taking 2 different statins (at least one being a moderate to high potency statin) for more than 2 weeks, the symptoms resolved when statin therapy was discontinued, and the patient has been rechallenged at a lower dose or with a different statin.

   [If yes, skip to question 7.]

5. Has the patient failed separate trials of at least 90 days each with 2 high intensity statins (e.g., atorvastatin 40 mg or greater and rosuvastatin 20 mg or greater) at maximum tolerated doses used in combination with other lipid lowering therapies such as ezetimibe or bile acid sequestrants? Y N

   NOTE: Pharmacy claim history will be reviewed to confirm refills.

   Please document medication regimens tried and reason for treatment failure: _____

   [If no, then no further questions.]

6. Will the requested drug be used in combination with a statin at a maximum tolerated dose? Y N

   [If no, then no further questions.]

7. Will the requested drug also be used in combination with other lipid lowering therapies such as ezetimibe or bile acid sequestrants? Y N

   Please document which treatment(s) will be used: _____

   [If no, then no further questions.]

8. Does the patient have a diagnosis of HETEROZYGOUS familial hypercholesterolemia (HeFH)? Y N

   [If no, skip to question 11.]

9. Is the diagnosis confirmed by at least ONE of the following: A) DNA based evidence of an LDL receptor (LDLR) mutation, APO-B100, or PCSK9 mutation; B) Who/Dutch Lipid Network Criteria result with a score of greater than 8 points; C) History of an LDL-C greater than 190 mg/dL (age Y N

18 years or older) either pretreatment or highest on treatment AND physical evidence of tendon xanthomas OR evidence of these signs in a 1st or 2nd degree relative?

NOTE: Medical records to support diagnosis must be submitted with request.

[If no, then no further questions.]

10. Does the patient have a fasting lipid profile within the previous 90 days that confirmed an LDL-C greater than or equal to 70mg/dL on the current lipid lowering regimen? Y N

    NOTE: Results of fasting lipid profile must be submitted with request.

    [If yes, skip to question 20.]

    [If no, then no further questions.]

11. Does the patient have a diagnosis of HOMOZYGOUS familial hypercholesterolemia (HoFH)? Y N

    [If no, skip to question 18.]

12. Does the patient have genetic confirmation of 2 mutant alleles at LDLR, APO-B100, or PCSK9? Y N

    NOTE: Medical records to support diagnosis must be submitted with request.

    [If yes, skip to question 15.]

13. Does the patient have a history of a treated LDL-C greater than or equal to 300mg/dL on maximum dosed statin OR an untreated LDL-C greater than or equal to 500mg/dL at any time? Y N

    NOTE: Results of fasting lipid profile must be submitted with request.

    [If no, then no further questions.]

14. Do BOTH of the patient's parents have HeFH OR did the patient have cutaneous xanthoma(s) present before the age of 10? Y N

    NOTE: Medical records to support diagnosis must be submitted with request.

    [If no, then no further questions.]

15. Does the patient have a fasting lipid profile within the previous 90 days that confirmed an LDL-C reduction of less than 50 percent on the current Y N

lipid lowering regimen (high intensity statin plus another treatment)?

NOTE: Results of fasting lipid profile must be submitted with request.

[If no, then no further questions.]

16. Is the request for Repatha? Y N

[If no, then no further questions.]

17. Is the patient at least 13 years old? Y N

[No further questions.]

18. Does the patient have clinical atherosclerotic cardiovascular disease (ASCVD)? Y N

NOTE: Evidence to support high CVD risk (i.e., history of acute coronary syndrome, history of MI, stable or unstable angina, coronary or other revascularization (PCI/CABG), stroke, TIA, peripheral arterial disease presumed to be of atherosclerotic origin must be submitted with request.

[If no, then no further questions.]

19. Does the patient have a fasting lipid profile within the previous 90 days that confirmed an LDL-C greater than or equal to 70mg/dL on the current lipid lowering regimen? Y N

NOTE: Results of fasting lipid profile must be submitted with request.

[If yes, skip to question 21.]

[If no, then no further questions.]

20. Is the patient at least 18 years old? Y N

[If no, then no further questions.]

21. Is the request for Repatha? Y N

[If yes, then no further questions.]

22. Has the patient had an inadequate response or intolerance to Repatha? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date