OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
PCSK9 Inhibitor Prior Authorization Form

Pharmacy Section

Member Name:_____ ***Date of Birth:***_____ ***Member ID#:***_____

Pharmacy NPI:_____ ***Pharmacy Phone:***_____ ***Pharmacy Fax:***_____

Pharmacy Name:_____ ***Pharmacist Name:***_____

Prescriber NPI:_____ ***Prescriber Name:***_____ ***Specialty:***_____

Prescriber Phone:_____ ***Prescriber Fax:***_____ ***Drug Name/Strength:***_____

NDC:_____ ***Regimen:***_____ ***Fill Quantity:***_____ ***Day Supply:***_____

Has member been trained on proper administration and storage of this medication? Yes☐ No☐

Pharmacist Signature: _____ **Date:** _____

Prescriber Section

***Page 1 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.* All information must be provided and SoonerCare may verify through further requested documentation. The member's prescription claim history will be reviewed prior to approval.**

For Initial Authorization (Initial approval will be for the duration of 3 months):

1. Please indicate member's diagnosis:
   - ☐ Heterozygous familial hypercholesterolemia (HeFH) confirmed by: ***(check all that apply)***
     - ☐ Documented functional mutation(s) in low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality via genetic testing **
     - ☐ Pre-treatment total cholesterol >290mg/dL or LDL-cholesterol (LDL-C) >190mg/dL
     - ☐ History of tendon xanthomas in either the member, first degree relative, or second degree relative
     - ☐ Dutch Lipid Clinic Network Criteria score of >8
   - ☐ Homozygous familial hypercholesterolemia (HoFH**)** confirmed by 1 or more of the following:
     - ☐ Documented functional mutation(s) in both LDL receptor alleles or alleles known to affect LDL receptor functionality via genetic testing**
     - ☐ Untreated LDL-C >500mg/dL and at least 1 of the following:
       - ☐ Documented evidence of definite HeFH in both parents
       - ☐ Presence of tendinous/cutaneous xanthoma prior to 10 years of age

   ***If this option is selected, genetic testing results must be submitted with the prior authorization request*
   - ☐ To reduce the risk of myocardial infarction, stroke, coronary revascularization, and/or unstable angina requiring hospitalization in adults with established cardiovascular disease (CVD). Please provide supporting diagnoses/ conditions and dates of occurrence signifying established CVD:
     Diagnosis/condition: _____ Date of occurrence:_____
     Diagnosis/condition: _____ Date of occurrence:_____
   - ☐ Primary hyperlipidemia
2. How will this medication be used? ☐ Monotherapy ☐ Adjunct to statin therapy, diet, and exercise
3. Please specify the member's current statin therapy:
   a) Medication/strength:_____ Dosing regimen:_____ Duration of treatment:_____
   b) Has member been adherent to high-dose statin therapy for at least 12 continuous weeks? Yes☐ No☐
   c) If yes, please provide member's LDL-C level following 12 weeks of statin therapy:_____
   SoonerCare claims analysis will be conducted to verify adherence.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
PCSK9 Inhibitor Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Prescriber Section

Page 2 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.
For Initial Authorization, Continued:

4. If the member has **not** been adherent to high-dose statin therapy for at least 12 continuous weeks, is the member intolerant to statin therapy? Yes☐ No☐
   a) If yes, please indicate 1 of the following:
   - ☐ Rhabdomyolysis - creatine kinase (CK) labs verifying this diagnosis must be provided.
   - ☐ An FDA labeled contraindication to all statins. Provide contraindication:_____
   - ☐ Documented intolerance to at least 2 different statins at lower doses or at intermittent dosing: Please provide all of the following:

     1) Medication/strength:_____ Dosing regimen:_____
        Duration of treatment:_____ Reason for discontinuation:_____
     2) Medication/strength:_____ Dosing regimen:_____
        Duration of treatment:_____ Reason for discontinuation:_____

5. Has the member had a recent trial of a statin with ezetimibe? Yes☐ No☐
   a) If yes, please provide statin tried with ezetimibe:_____ trial dates:_____
6. If the member is intolerant to statin therapy, has the member had a recent trial of ezetimibe alone? Yes☐ No☐
   a) If yes, please provide ezetimibe trial dates:_____
7. Please provide member's LDL-C level following ezetimibe therapy with statin therapy or without statin therapy:_____
8. If ezetimibe has not been tried either with or without a statin, please provide a patient-specific, clinically significant reason why ezetimibe is not appropriate for the member:_____
9. Member's baseline LDL-C:_____ Current LDL-C:_____ Goal LDL-C:_____
10. Has the member been counseled on proper administration and storage of PCSK9 therapy? Yes☐ No☐

For Continued Authorization:
1. Has member been compliant with PCSK9 Inhibitor treatment? Yes☐ No☐
2. Has PCSK9 Inhibitor treatment been effective for this member? Yes☐ No☐
3. Please provide a recent LDL-C level for this member:_____ Date taken:_____

Prescriber Signature: _____ **Date:** _____
By signature, the physician confirms the criteria information above is accurate and verifiable in patient records. Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

Member (Patient) Section For Initial Authorization Only

Please have the member initial after each line, fill in all blanks, and sign at the bottom.
1. I understand this medicine must be injected. **Initials:** _____
2. I understand I must give myself a shot every _____ week(s). **Initials:** _____
3. I understand this medication must be kept in the refrigerator. **Initials:** _____
4. I will not leave this medication in the car or anywhere it would get hot. **Initials:** _____
5. I understand this medication will not be replaced if I leave it out of the refrigerator. **Initials:** _____

Member Signature: _____ **Date:** _____

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4