

Praluent® (alirocumab) Prior Authorization Form

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

Drug Information

Pharmacy Billing (NDC: _____) Start Date (or date of next dose): _____

Dose: _____ Regimen: _____

Pharmacy Information

Pharmacy NPI: _____ Pharmacy Name: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria**For Initial Authorization** (Initial approval will be for the duration of 6 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 (**results of genetic testing must be submitted**)
 - 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) defined by the presence of at least 1 of the following:**
- Documented functional mutation(s) in both LDL receptor alleles or alleles known to affect LDL receptor functionality via genetic testing (**results of genetic testing must be submitted**)
 - 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
- To reduce the risk of major adverse cardiovascular (CV) events (coronary heart disease death, myocardial infarction, stroke, and unstable angina requiring hospitalization) in adults at increased risk for these events. Please provide supporting diagnoses/conditions/risk factors signifying increased risk of major adverse CV events:** _____
- Primary hyperlipidemia**
Untreated LDL-C level: _____ (mg/dL); Current LDL-C level: _____ (mg/dL)
- Other:** _____

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.

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PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization UnitFax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4CONFIDENTIALITY NOTICE

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

Criteria

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. Will member be counseled on appropriate use, storage of the medication, and administration technique? Yes ___ No ___

For Continued Authorization:

- 1. Has member been compliant with alicumab treatment? Yes ___ No ___
2. Has alicumab treatment been effective for this member? Yes ___ No ___
3. Please provide a recent LDL-C level for this member: Date taken:

Additional Information: _____

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Prescriber Signature: _____ Date: _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. 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.

Table with 2 columns: 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) and CONFIDENTIALITY NOTICE (This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.)