



Repatha® (evolocumab) 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:
- Homozygous familial hypercholesterolemia (HoFH) defined by the presence of at least 1 of the following:
- To reduce the risk of major adverse cardiovascular (CV) events...
- Primary hyperlipidemia
2. How will this medication be used?
3. Please specify the member's current statin therapy:

Table with 2 columns: PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO: (University of Oklahoma College of Pharmacy) and CONFIDENTIALITY NOTICE (This document, including any attachments, contains information which is confidential or privileged.)

**Repatha® (evolocumab) Prior Authorization Form**

**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 the member be counseled on appropriate use, storage of the medication, and administration technique?  
Yes \_\_\_ No \_\_\_

**For Continued Authorization:**

1. Has member been compliant with evolocumab? Yes \_\_\_ No \_\_\_
2. Has evolocumab 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.*

<p><u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u></p> <p>University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit</p> <p>Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4</p>	<p><u>CONFIDENTIALITY NOTICE</u></p> <p><i>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.</i></p>
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