UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

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<tr>
<th>Program Number</th>
<th>2018 P 2062-9</th>
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<tr>
<td>Program</td>
<td>Prior Authorization/Medical Necessity</td>
</tr>
<tr>
<td>Medication</td>
<td>Praluent™ (alirocumab)</td>
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<tr>
<td>Effective Date</td>
<td>3/1/2019; Oxford only: 3/1/2019</td>
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1. **Background:**
   Praluent™ (alirocumab) is a PCSK9 (Proprotein Convertase Subtilisin Kexin Type 9) inhibitor antibody indicated as adjunct to diet and maximally tolerated statin therapy for the treatment of adults with heterozygous familial hypercholesterolemia or clinical atherosclerotic cardiovascular disease, who require additional lowering of LDL-cholesterol (LDL-C).¹

2. **Coverage Criteria**:
   A. **Hyperlipidemia**
   
   1. **Initial Authorization**
   
   a. **Praluent** will be approved based on **all** of the following criteria:

   (1) **One** of the following diagnoses:

   (a) Heterozygous familial hypercholesterolemia (HeFH) as confirmed by **one** of the following*:¹⁴⁻¹⁶

   i. **Both** of the following:*¹⁴⁻¹⁶

   1. Pre-treatment LDL-C greater than 190 mg/dL (greater than 155 mg/dL if less than 16 years of age)

   -AND-

   2. **One** of the following:

   a. Family history of myocardial infarction in first-degree relative < 60 years of age
   b. Family history of myocardial infarction in second-degree relative <50 years of age
   c. Family history of LDL-C greater than 190 mg/dL in first- or second-degree relative
   d. Family history of familial hypercholesterolemia in first- or second-degree relative

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e. Family history of tendinous xanthomata and/or arcus
cornealis in first- or second degree relative

-OR-

ii. Both of the following:14-16

1. Pre-treatment LDL-C greater than 190 mg/dL (greater than 155
mg/dL if less than 16 years of age)

-AND-

2. Submission of medical records (e.g., chart notes, laboratory
values) documenting one of the following:

a. Functional mutation in LDL, apoB, or PCSK9 gene*
b. Tendinous xanthomata
c. Arcus cornealis before age 45

-OR-

(b) Atherosclerotic cardiovascular disease (ASCVD) as confirmed by one
of the following:

i. Acute coronary syndromes
ii. History of myocardial infarction
iii. Stable or unstable angina
iv. Coronary or other arterial revascularization
v. Stroke
vi. Transient ischemic attack
vii. Peripheral arterial disease presumed to be of atherosclerotic origin

-AND-

(2) Submission of medical records (e.g., chart notes, laboratory values)
documenting one of the following [prescription claims history may be
used in conjunction as documentation of medication use, dose, and
duration]:

(a) Patient has been receiving at least 12 consecutive weeks of high
intensity statin therapy [i.e. atorvastatin 40-80 mg, rosvastatin 20-
40 mg] and will continue to receive a high intensity statin at
maximally tolerated dose

-OR-
(b) **Both** of the following:

i. Patient is unable to tolerate high-intensity statin as evidenced by **one** of the following intolerable and persistent (i.e. more than 2 weeks) symptoms:

   1. Myalgia (muscle symptoms without CK elevations)
   2. Myositis (muscle symptoms with CK elevations < 10 times upper limit of normal [ULN])

   -AND-

ii. **One** of the following:

   1. Patient has been receiving at least 12 consecutive weeks of **moderate-intensity** [i.e. atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin ≥ 20 mg, pravastatin ≥ 40 mg, lovastatin 40 mg, Lescol XL (fluvastatin XL) 80 mg, fluvastatin 40 mg twice daily or Livalo (pitavastatin) ≥ 2 mg] and will continue to receive a moderate-intensity statin at maximally tolerated dose

   -OR-

   2. Patient has been receiving at least 12 consecutive weeks of **low-intensity** [i.e. simvastatin 10 mg, pravastatin 10-20 mg, lovastatin 20 mg, fluvastatin 20-40 mg, or Livalo (pitavastatin) 1 mg] statin therapy and will continue to receive a low-intensity statin at maximally tolerated dose

   -OR-

(c) Patient is unable to tolerate **low or moderate-, and high-intensity statins** as evidenced by **one** of the following:

i. **One** of the following intolerable and persistent (i.e. more than 2 weeks) symptoms for low or moderate-, and high-intensity statins:

   1. Myalgia (muscle symptoms without CK elevations)
   2. Myositis (muscle symptoms with CK elevations < 10 times upper limit of normal [ULN])

   -OR-
ii. Patient has a labeled contraindication to all statins as documented in medical records

-OR-

iii. Patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations > 10 times ULN

-AND-

(3) **One** of the following:

(a) Submission of medical record (e.g., laboratory values) documenting **one** of the following LDL-C values while on maximally tolerated lipid lowering therapy within the last 120 days:

i. LDL-C ≥ 100 mg/dL with ASCVD

ii. LDL-C ≥ 130 mg/dL without ASCVD

-OR-

(b) **Both** of the following:

i. Submission of medical record (e.g., laboratory values) documenting **one** of the following LDL-C values while on maximally tolerated lipid lowering therapy within the last 120 days:

1. LDL-C between 70 mg/dL and 99 mg/dL with ASCVD

2. LDL-C between 100 mg/dL and 129 mg/dL without ASCVD

-AND-

ii. Submission of medical record (e.g., chart notes, laboratory values) documenting **one** of the following [prescription claims history may be used in conjunction as documentation of medication use, dose, and duration]:

1. Patient has been receiving at least 12 consecutive weeks of ezetimibe (Zetia®) therapy as adjunct to maximally tolerated statin therapy

-OR-
2. Patient has a history of contraindication, or intolerance to ezetimibe

-AND-

(4) Used as an adjunct to a low-fat diet and exercise

-AND-

(5) Prescribed by one of the following:
   (a) Cardiologist
   (b) Endocrinologist
   (c) Lipid specialist

-AND-

(6) Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor

-AND-

(7) Prescriber attests to the following: the information provided is true and accurate to the best of their knowledge and they understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided

*Results of prior genetic testing can be submitted as confirmation of diagnosis of HeFH, however please note that UnitedHealthcare does not currently cover genetic testing for evidence of an LDL-receptor mutation, familial defective apo B-100 or a PCSK9 mutation.

\[\text{No coverage of Praluent will be provided for the primary prevention of cardiovascular events and/or for the lowering of low-density lipoprotein cholesterol in patients with primary hyperlipidemia who do not have heterozygous familial hypercholesterolemia or established atherosclerotic cardiovascular disease (ASCVD) as the use of PCSK9 inhibitors in this population is not supported by the 2018 American College of Cardiology/American Heart Association Cholesterol Clinical Practice Guidelines.}\]

**Authorization will be issued for 6 months**

2. **Reauthorization**

   a. Praluent will be approved based on all of the following criteria:
(1) Patient continues to receive statin at maximally tolerated dose (unless patient has documented inability to take statins)

-AND-

(2) Patient is continuing a low-fat diet and exercise regimen

-AND-

(3) Prescribed by one of the following:
   
   (a) Cardiologist
   (b) Endocrinologist
   (c) Lipid specialist

-AND-

(4) Submission of medical records (e.g. chart notes, laboratory values) documenting LDL-C reduction while on Praluent therapy

-AND-

(5) Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor

-AND-

(6) Prescriber attests to the following: the information provided is true and accurate to the best of their knowledge and they understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided.

Authorization will be issued for 12 months

* State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.
3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.
- Step therapy may be in place.

References:


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<thead>
<tr>
<th>Program</th>
<th>Prior Authorization/Medical Necessity - Praluent™ (alirocumab)</th>
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<tbody>
<tr>
<td>Change Control</td>
<td></td>
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<tr>
<td>5/2015</td>
<td>New program.</td>
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<tr>
<td>5/2015</td>
<td>Added examples of atherosclerotic cardiovascular disease.</td>
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<tr>
<td>8/2015</td>
<td>Revised clinical criteria</td>
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<tr>
<td>9/2015</td>
<td>Revised clinical criteria to include combination use of high-intensity statin or documented intolerance to high-, moderate- and low intensity statin therapy to achieve the maximally tolerated statin therapy.</td>
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<tr>
<td>7/2016</td>
<td>Added Indiana and West Virginia coverage information.</td>
</tr>
<tr>
<td>9/2016</td>
<td>Added Connecticut and Kentucky coverage information. Updated references.</td>
</tr>
<tr>
<td>11/2016</td>
<td>Added California coverage information.</td>
</tr>
<tr>
<td>12/2016</td>
<td>Modified medical record criteria to include review of prescription claims history. Updated references.</td>
</tr>
<tr>
<td>11/2017</td>
<td>Updated medical record requirement, modified criteria for HeFH diagnosis, modified previous statin requirement requiring failure, intolerance to high intensity and either moderate or low intensity statin. Modified target LDL values and ezetimibe trial requirement. Extended timeline for lipid panel submission to 120 days. Added physician attestation criterion. Updated state mandate verbiage. Updated references.</td>
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<tr>
<td>12/2018</td>
<td>Annual review. Updated formatting without changes to clinical intent. Updated references.</td>
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