UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 2062-21
Program	Prior Authorization/Medical Necessity
Medication	Praluent® (alirocumab)*
P&T Approval Date	5/2015, 8/2015, 9/2015, 9/2016, 12/2016, 11/2017, 12/2018, 12/2019, 2/2020, 2/2021, 6/2021, 8/2021, 6/2022, 1/2023, 6/2023, 10/2023, 2/2024, 5/2024, 2/2025
Effective Date	5/1/2025

1. Background:

Praluent® (alirocumab) is a PCSK9 (Proprotein Convertase Subtilisin Kexin Type 9) inhibitor indicated[1]:

- To reduce the risk of myocardial infarction, stroke, and unstable angina requiring hospitalization in adults with established cardiovascular disease.
- As adjunct to diet, alone or in combination with other low-density lipoprotein cholesterol (LDL-C)-lowering therapies (e.g., statins, ezetimibe, LDL apheresis), for the treatment of adults with primary hyperlipidemia (including heterozygous familial hypercholesterolemia) to reduce LDL-C.
- As an adjunct to other LDL-C-lowering therapies in adult patients with homozygous familial hypercholesterolemia (HoFH) to reduce LDL-C.
- As an adjunct to diet and other LDL-C-lowering therapies in pediatric patients aged 8 years and older with HeFH to reduce LDL-C.

2. Coverage Criteria[a]:

A. <u>Primary Hyperlipidemia (including heterozygous familial hypercholesterolemia) and ASCVD</u>

a. **Praluent*** will be approved based on **<u>all</u>** of the following criteria:

(1) **<u>One</u>** of the following diagnoses:

(a) Heterozygous familial hypercholesterolemia (HeFH)

-OR-

(b) Atherosclerotic cardiovascular disease (ASCVD) (e.g., acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack, or peripheral arterial disease presumed to be of atherosclerotic origin)

-OR-

(c) Primary hyperlipidemia

-AND-

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

(a) Patient has been receiving at least 12 consecutive weeks **of high-intensity statin therapy** [i.e., atorvastatin 40-80 mg, rosuvastatin 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 creatine kinase (CK) elevations]
2. Myositis (muscle symptoms with CK elevations < 10 times upper limit of normal [ULN])

-AND-

ii. Patient has been receiving at least 12 consecutive weeks of low-intensity or moderate-intensity statin therapy [i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin ≥ 10 mg, pravastatin ≥ 10 mg, lovastatin 20-40 mg, fluvastatin XL 80 mg, fluvastatin 20-40 mg up to 40mg twice daily or Livalo (pitavastatin) ≥ 1 mg] and will continue to receive a low-intensity or moderate-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 contraindication to all statins

-OR-

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

-AND-

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

(a) Patient has LDL-C greater than or equal to 55 mg/dL

-AND-

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

i. Patient has been receiving at least 12 consecutive weeks of ezetimibe therapy as adjunct to maximally tolerated statin therapy

-OR-

ii. Patient has a history of contraindication, or intolerance to ezetimibe

-AND-

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

(a) Patient is less than 10 years of age

-OR-

(b) History of failure, contraindication, or intolerance to Repatha (evolocumab) (document date of trial and list reason for therapeutic failure, contraindication, or intolerance)

-AND-

(5) Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Repatha (evolocumab)]

-AND-

(6) Not used in combination with Leqvio (inclisiran)

Authorization will be issued for 12 months

B. **Homozygous Familial Hypercholesterolemia**

a. **Praluent*** will be approved based on **all** of the following criteria:

(1) Diagnosis of homozygous familial hypercholesterolemia (HoFH) as confirmed by **one** of the following:

(a) Submission of medical records (e.g., chart notes, laboratory values) confirming genetic confirmation of bi-allelic pathogenic/likely pathogenic variants on different chromosomes at the low-density lipoprotein receptor

(*LDLR)*, apolipoprotein B (*APOB)*, proprotein convertase subtilisin kexin type 9 (*PCSK9)*, or low-density lipoprotein receptor adaptor protein 1 (*LDLRAP1)* genes or ≥ 2 such variants at different loci

-OR-

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

i. Untreated LDL-C greater than 400 mg/dL

-AND-

ii. **One** of the following:

- Xanthoma before 10 years of age
- Evidence of familial hypercholesterolemia in at least one parent

-AND-

(2) Patient is receiving other lipid-lowering therapy (e.g., statin, ezetimibe, LDL apheresis)

-AND-

(3) Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Repatha (evolocumab)]

-AND-

(4) Not used in combination with Juxtapid (lomitapide)

-AND-

(5) History of failure, contraindication, or intolerance to Repatha (evolocumab) (document date of trial and list reason for therapeutic failure, contraindication, or intolerance)

Authorization will be issued for 12 months.

[a] 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.

*Praluent is typically excluded from coverage. Tried/Failed criteria may be in place. Please refer to plan specifics to determine exclusion status.

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 and Step therapy may be in place

4. References:

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Program	Prior Authorization/Medical Necessity - Praluent® (alirocumab)
Change Control	
5/2015	New program.
5/2015	Added examples of atherosclerotic cardiovascular disease.
8/2015	Revised clinical criteria
9/2015	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.
7/2016	Added Indiana and West Virginia coverage information.
9/2016	Added Connecticut and Kentucky coverage information. Updated references.
11/2016	Added California coverage information.
12/2016	Modified medical record criteria to include review of prescription claims history. Updated references.
11/2017	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.
12/2018	Annual review. Updated formatting without changes to clinical intent. Updated references.
12/2019	Annual review. Updated background information without change to clinical coverage criteria. Updated references.
2/2020	Updated criteria providing clarity on laboratory monitoring requirements. Updated reference.
2/2021	Annual review with no change to coverage criteria. References updated.
6/2021	Added Praluent exclusion statement. Added history of failure, contraindication, or intolerance to Repatha to all criteria. Removed prescriber specialist requirement. Removed submission of medical

	records requirement throughout criteria. Changed initial authorization duration to 12 months to align all PCSK9 programs. Removed reauthorization criteria. Added HoFH criteria per new indication. Updated references.
8/2021	Updated LDL-C requirement to 120 days or 120 days prior to starting PCSK9 inhibitor therapy.
6/2022	Annual review. Condensed low intensity and moderate-intensity statin therapy sections. Updated exclusion statement.
1/2023	Lowered LDL-C threshold requirement for initiation of Praluent therapy per American College of Cardiology guidance. Removed genetic testing coverage footnote. Updated references.
6/2023	Annual review. Updated background. Added criteria that Praluent is not to be used in combination with Leqvio and updated diet requirement.
10/2023	Removed “routine audit” language from criteria. Updated and clarified criteria for patients with primary hyperlipidemia with baseline LDL-C level ≥ 190 on statin therapy for primary prevention per American College of Cardiology guidance. Updated background.
2/2024	Updated diagnostic criteria per European Atherosclerosis Society guidance. Updated references.
5/2024	Added criterion for patients less than 10 years of age to align with new label for pediatric patients aged 8 years and older with HeFH. Updated background and reference.
2/2025	Simplified diagnosis requirements for HeFH, ASCVD, and primary hyperlipidemia. Removed diet requirement. Revised HoFH criteria to include more precise genetic terminology to account for genetic test result interpretation complexity as well as digenic mutations. Lowered LDL-C threshold from 100 to 55 mg/dL. Updated background and references.