

Specialty Medication Prior Authorization Cover Sheet

(This cover sheet should be submitted along with a Pharmacy Prior Authorization Medication Fax Request Form. Please refer to www.uhccommunityplan.com for medication fax request forms.)

Patient Information

Patient's Name: _____

Insurance ID: _____ Date of Birth: _____ Height: _____ Weight: _____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Alternate Phone: _____ Sex: Male Female

Provider Information

Provider's Name: _____ Provider ID Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Suite Number: _____ Building Number: _____

Phone Number: _____ Fax number: _____

Provider's Specialty: _____

Medication Information

Medication: _____ Quantity: _____ ICD10 Code: _____

Directions: _____ Diagnosis: _____ Refills: _____

Physician Signature**: _____ Initial here if DAW: _____

*Physician Signature**: By signing above, the physician is providing the specialty pharmacy with a prescription that can be used to facilitate the dispensing and/or coordination of delivery for the requested medication.*

Medication Instructions

Has the patient been instructed on how to **Self-Administer**? Yes No

Is this medication a **New Start**? Yes No

If continuation please provide the following: Initiation Date: / / Date of Last Dose: / /

Is there documentation of positive clinical response to current therapy? Yes No

****Please attach any pertinent clinical information that would pertain to support stated diagnosis. Additional clinical information may be needed depending on your patients plan, including medication(s) previously tried and failed.**

Delivery Instructions

Note: Delivery coordination requires a "Physician Signature" above and complete "Provider Information" and "Patient Information"

Note: All necessary ancillary supplies are provided free of charge to the patient at the time of delivery

Ship to: Physician's Office Patient's Address Date medication is needed: / /

Medication Administered: Home Health Self-Administered LTC Physician's Office

Antihyperlipidemics, PCSK9 Inhibitors - Washington

PRIOR AUTHORIZATION REQUEST FORM

Please complete this entire form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.

This form contains multiple pages. Please complete all pages to avoid a delay in our decision.

Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information:		
Is the requested medication <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____		

Section B - Provider Information

First Name:	Last Name:	M.D./D.O.
Address:	City:	State: ZIP code:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax attention to:		

Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

ALL REQUESTS:

- **What is the patient's diagnosis? (check which applies)**
 - Heterozygous familial hypercholesterolemia (HeFH)
 - Primary hypercholesterolemia with atherosclerotic cardiovascular disease (ASCVD)
 - Homozygous Familial Hypercholesterolemia (HoFH)
 - Reducing the risk of myocardial infarction, stroke, and coronary revascularization in adults with established cardiovascular disease (CVD)
 - None of the above, **List diagnosis:** _____

- **Does the patient have concomitant therapy with the highest-tolerated statin regimen for at least 6 consecutive weeks or is statin intolerant?** Yes No
 (If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- **Has the patient's LDL achieved at least 50% reduction from baseline? (since being on the highest-tolerated statin regimen for at least 6 consecutive weeks)** Yes No
 If yes, **List LDL reduction from baseline:** _____

- **Has the patient's LDL remained $\geq 100\text{mg/dL}$? (since being on the highest-tolerated statin regimen for at least 6 consecutive weeks)** Yes No If yes, **List LDL:** _____

- **Will the requested medication be used in combination with either of the following:** Yes No
(check which applies)
 - Another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor
 - Juxtapid (lomitapide)
 - Kynamro (mipomersen)

- **Is the requested medication being prescribed by, or in consultation with, a provider specializing in lipid management? (e.g. cardiologist, lipid specialist, or endocrinologist)** Yes No

- **Has the patient demonstrated failure or intolerance to one preferred Antihyperlipidemics - PCSK9 Inhibitor? (check which applies)** Yes No N/A (No preferred formulary alternative available)
 (If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)
 If no, list reason: _____

Requests for HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH):

- **Has the patient's diagnosis been defined by one of the following:** Yes No **(check which applies)**
 - Clinical diagnosis using diagnostic tools such as US MedPed, Simon Broome Register Group, or Dutch Lipid Panel
List diagnostic tool: _____
 - Age ≥ 20 and LDL $\geq 190\text{mg/dL}$ on maximally tolerated statin therapy prior to adding a PCSK9 Inhibitor
List age / LDL / statin and dose: _____
 - Age < 20 and LDL $\geq 160\text{mg/dL}$ on maximally tolerated statin therapy prior to adding a PCSK9 Inhibitor
List age / LDL / statin and dose: _____
 - Genetic typing confirming presence of familial hypercholesterolemia genes
 - None of the above List: _____

Requests for HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HOFH):

- **Has the patient's diagnosis been defined by one of the following:** Yes No **(check which applies)**
 - History of untreated LDL $\geq 500\text{mg/dL}$ with a xanthoma before 10 years of age
List LDL / age of xanthoma: _____
 - Evidence of heterozygous familial hypercholesterolemia in both parents: _____
 - Genetic typing confirming presence of familial hypercholesterolemia genes
 - None of the above, List: _____

- **Has the patient's LDL remained $\geq 130\text{mg/dL}$? (since being on the highest-tolerated statin regimen for at least 6 consecutive weeks)** Yes No If yes, **List LDL:** _____

Member First name:	Member Last name:	Member DOB:
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Requests for PRIMARY HYPERCHOLESTEROLEMIA WITH ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD) & REDUCING THE RISK OF MYOCARDIAL INFARCTION, STROKE, AND CORONARY REVASCULARIZATION IN ADULTS WITH ESTABLISHED CARDIOVASCULAR DISEASE (CVD):

- Does the patient have history of at least one of the following: Yes No (check which applies)

- Myocardial infarction (MI), presumed to be of atherosclerotic origin
- Acute coronary syndrome (ACS), presumed to be of atherosclerotic origin
- Severe angina, presumed to be of atherosclerotic origin
- Stroke, presumed to be of atherosclerotic origin
- Transient ischemic attack (TIA), presumed to be of atherosclerotic origin
- Coronary revascularization procedures, presumed to be of atherosclerotic origin
- Peripheral arterial disease, presumed to be of atherosclerotic origin
- None of the above, List: _____

Requests for CONTINUATION OF THERAPY:

- Does the patient continue to receive the maximum tolerated dose of statin, unless contraindicated or intolerant to statin therapy? Yes No

If yes, list statin / dose: _____

- Is there documentation of continued clinical benefit? (e.g. at least a 30% reduction in LDL from initiation of PCSK9 Inhibitor or achievement of patient-specific goal) Yes No

If yes, list clinical benefit: _____

Physician Signature: _____ **Date:** _____

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