UnitedHealthcare Community Plan

Praluent
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 may contain 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 (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
NPI #:	Phone:	Fax:	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? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	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

UnitedHealthcare Community Plan

Praluent
Prior Authorization Request Form

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS

□ **Yes** □ **No**	**Does the patient have any of the following diagnoses?** *(Check which apply)* □ Heterozygous familial hypercholesterolemia (HeFH) □ Atherosclerotic cardiovascular disease (ASCVD)
□ **Yes** □ **No**	**Is there submission of medical records (e.g., chart notes, laboratory values) documenting the patient has been receiving at least 12 consecutive weeks of high-intensity statin therapy and will continue to receive high-intensity statin at maximally tolerated dose?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Is the patient unable to tolerate high-intensity statin as evidenced by one of the following intolerable and persistent (i.e. more than 2 weeks) symptoms: myalgia (muscle symptoms without CK elevations), or myositis (muscle symptoms with CK elevations < 10 times upper limit of normal [ULN])?** *If yes, list intolerance:*
□ **Yes** □ **No**	**Is there submission of medical records (e.g., chart notes, laboratory values) documenting the patient has been receiving at least 12 consecutive weeks of moderate-intensity statin therapy and will continue to receive a moderate-intensity at maximally tolerated dose?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Is there submission of medical records (e.g., chart notes, laboratory values) documenting the patient has been receiving at least 12 consecutive weeks of low-intensity statin therapy and will continue to receive a low-intensity at maximally tolerated dose?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Is the patient unable to tolerate low- or moderate-, and high-intensity statins as evidenced by one of the following:** *(If yes, check which applies and complete Section D above)* □ One of the following intolerable and persistent (i.e. more than 2 weeks) symptoms: myalgia (muscle symptoms without CK elevations), or myositis (muscle symptoms with CK elevations < 10 times upper limit of normal [ULN]) □ Patient has a labeled contraindication to all statins as documented in medical records □ Patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations > 10 times ULN
List LDL-C values while on maximally tolerated lipid lowering therapy: _____ mg/dL Date: _____ ***(Required)***	
□ **Yes** □ **No**	**Is there submission of medical records (e.g., chart notes, laboratory values) documenting either of the following:** *(If yes, check which applies and complete Section D above)* □ Patient has been receiving at least 12 consecutive weeks of ezetimibe (Zetia) therapy as adjunct to maximally tolerated statin therapy □ Patient has a history of contraindication or intolerance to ezetimibe
□ **Yes** □ **No**	**Is this used as an adjunct to a low-fat diet and exercise?**
□ **Yes** □ **No**	**Is this prescribed by a cardiologist, endocrinologist, or lipid specialist?**
□ **Yes** □ **No**	**Will this be used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor?** *(If yes, complete Section D above)*

HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HeFH)

List pre-treatment LDL-C: _____ ***(Required)***

□ **Yes** □ **No**	**Does the patient have one of the following:** *(check which applies)* □ Family history of myocardial infarction in first-degree relative < 60 years of age □ Family history of myocardial infarction in second-degree relative < 50 years of age □ Family history of LDL-C greater than 190 mg/dL in first- or second-degree relative □ Family history of familial hypercholesterolemia in first- or second-degree relative □ Family history of tendinous xanthomata and/or arcus cornealis in first- or second-degree relative
□ **Yes** □ **No**	**Is there submission of medical records (e.g., chart notes, laboratory values) documenting any of the following:** *(check which apply)* □ Functional mutation in LDL, apoB, or PCSK9 gene* □ Tendinous xanthomata □ Arcus cornealis before age 45

UnitedHealthcare Community Plan

Praluent
Prior Authorization Request Form

Member First name:	Member Last name:	Member DOB:

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD)	
□ **Yes** □ **No**	**Is ASCVD confirmed by <u>one</u> of the following:** *(check which apply)* □ Acute coronary syndromes □ Stable or unstable angina □ Stroke □ Peripheral arterial disease presumed to be of atherosclerotic origin □ History of myocardial infarction □ Coronary or other arterial revascularization □ Transient ischemic attack
CONTINUATION OF THERAPY	
□ **Yes** □ **No**	**Does the patient continue to receive a statin at the maximally tolerated dose (unless the patient has documented inability to take statins)?** *If yes, list dose or reason:*
□ **Yes** □ **No**	**Is the patient continuing a low-fat diet and exercise regimen?**
□ **Yes** □ **No**	**Is Praluent prescribed by <u>one</u> of the following:** *(check which apply)* □ Cardiologist □ Endocrinologist □ Lipid specialist
□ **Yes** □ **No**	**Is there submission of medical records (e.g., chart notes, laboratory values) documenting LDL-C reduction while on Praluent therapy?** *If yes, list LDL-C value and date:*
□ **Yes** □ **No**	**Will Praluent be used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor?** *(If yes, complete Section D above)*
☐ **Does the prescriber attest 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.**	

Provider Signature: _____ **Date:** _____