ROCKY MOUNTAIN HEALTH PLANS®
A UnitedHealthcare Company

Prior Authorization Request Form
Fax Back To: (866) 940-7328
Phone: (800) 310-6826

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.uhcprovider.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 ☐

ROCKY MOUNTAIN HEALTH PLANS®
A UnitedHealthcare Company

Repatha - Colorado
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 □ 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:
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? □ Yes □ 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 at www.uhcprovider.com for a list of preferred alternatives

ROCKY MOUNTAIN HEALTH PLANS®
A UnitedHealthcare Company

Repatha - Colorado
Prior Authorization Request Form

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

	ALL REQUESTS
□ **Yes** □ **No**	**Does the prescriber attest that the information provided below 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?**
□ **Yes** □ **No**	**Does the patient have any of the following diagnoses?** *(If yes, check which applies)* □ Atherosclerotic cardiovascular disease (ASCVD) □ Heterozygous familial hypercholesterolemia (HeFH) □ Homozygous familial hypercholesterolemia (HoFH)
□ **Yes** □ **No**	**Will Repatha be used as an adjunct to a low-fat diet and exercise?**
□ **Yes** □ **No**	**Is Repatha prescribed by any of the following?** *(If yes, check which applies)* □ Cardiologist □ Endocrinologist □ Lipid Specialist
□ **Yes** □ **No**	**Will Repatha be used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Praluent (alirocumab)]?**
	ASCVD & HeFH
□ **Yes** □ **No**	**Will medical records (e.g., chart notes, laboratory values) documenting the 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 high intensity statin at maximally tolerated dose be submitted?** *DOCUMENTATION REQUIRED*
□ **Yes** □ **No**	**Is the patient is unable to tolerate high-intensity statin as evidenced by any of the following intolerable and persistent (i.e. more than 2 weeks) symptoms?** *(If yes, check which applies)* □ Myalgia (muscle symptoms without creatine kinase [CK] elevations) □ Myositis (muscle symptoms with CK elevations < 10 times upper limit of normal [ULN])
□ **Yes** □ **No**	**Will medical records (e.g., chart notes, laboratory values) documenting the patient has been receiving at least 12 consecutive weeks of moderate-intensity statin therapy [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 be submitted?** *DOCUMENTATION REQUIRED*
□ **Yes** □ **No**	**Will medical records (e.g., chart notes, laboratory values) documenting the patient has been receiving at least 12 consecutive weeks of low-intensity statin therapy [i.e. simvastatin 10 mg, pravastatin 10-20 mg, lovastatin 20 mg, fluvastatin 20-40 mg, or Livalo (pitavastatin) 1 mg] and will continue to receive a low-intensity statin at maximally tolerated dose be submitted?** *DOCUMENTATION REQUIRED*
□ **Yes** □ **No**	**Is the patient is unable to tolerate low- or moderate-, and high-intensity statins as evidenced by any of the following intolerable and persistent (i.e. more than 2 weeks) symptoms for low- or moderate-, and high-intensity statins?** *(If yes, check which applies)* □ Myalgia (muscle symptoms without CK elevations) □ Myositis (muscle symptoms with CK elevations < 10 times upper limit of normal [ULN])
□ **Yes** □ **No**	**Will medical records (e.g., chart notes, laboratory values) documenting the patient has a labeled contraindication to all statins be submitted?** *DOCUMENTATION REQUIRED*
□ **Yes** □ **No**	**Will medical records (e.g., chart notes, laboratory values) documenting the patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations > 10 times the upper limit of normal (ULN) be submitted?** *DOCUMENTATION REQUIRED*
□ **Yes** □ **No**	**Will medical record (e.g., laboratory values) documenting any of the following LDL-C values while on maximally tolerated lipid lowering therapy for a minimum of at least 12 weeks within the last 120 days be submitted?** *(If yes, check which applies. DOCUMENTATION REQUIRED)* □ LDL-C ≥ 100 mg/dL with ASCVD □ LDL-C between 70 mg/dL and 99 mg/dL with ASCVD □ LDL-C ≥ 130 mg/dL without ASCVD □ LDL-C between 100 mg/dL and 129 mg/dL without ASCVD
□ **Yes** □ **No**	**Will medical record (e.g., chart notes, laboratory values) documenting the patient has any of the following be submitted?** *(If yes, check which applies. DOCUMENTATION REQUIRED)* □ 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

ROCKY MOUNTAIN HEALTH PLANS®
A UnitedHealthcare Company

Repatha - Colorado
Prior Authorization Request Form

Member First name:	Member Last name:	Member DOB:

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD)	
□ **Yes** □ **No**	**Does the patient have ASCVD as confirmed by any of the following?** *(If yes, check which applies)* □ Acute coronary syndromes □ Coronary or other arterial revascularization □ History of myocardial infarction □ Peripheral arterial disease presumed to be of atherosclerotic origin □ Stable or unstable angina □ Stroke □ Transient ischemic attack
HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH)	
□ **Yes** □ **No**	**Was the patient's diagnosis of HeFH confirmed by a pre-treatment LDL-C of any of the following?** *(If yes, check which applies)* □ Greater than 190 mg/dL □ Greater than 155 mg/dL if less than 16 years of age
□ **Yes** □ **No**	**Does the patient have any of the following?** *(If yes, 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 heterozygous or homozygous 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**	**Will medical records (e.g., chart notes, laboratory values) documenting the patient has any of the following be submitted?** *(If yes, check which applies. DOCUMENTATION REQUIRED)* □ Arcus cornealis before age 45 □ Functional mutation in LDL (low density lipoprotein), apoB (apolipoprotein B), or PCSK9 (proprotein convertase subtilisin/kexin type 9) gene □ Tendinous xanthomata
HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HOFH)	
□ **Yes** □ **No**	**Has the patient's diagnosis of HoFH been confirmed by submission of medical records (e.g., chart notes, laboratory values) documenting any of the following?** *(If yes, check which applies. DOCUMENTATION REQUIRED)* □ Pre-treatment LDL-C greater than 500 mg/dL □ Treated LDL-C greater than 300 mg/dL □ Xanthoma before 10 years of age □ Evidence of heterozygous familial hypercholesterolemia (HeFH) in both parents
□ **Yes** □ **No**	**Is the patient receiving other lipid-lowering therapy (e.g., statin, ezetimibe, LDL [low-density lipoprotein] apheresis)?**
□ **Yes** □ **No**	**Will Repatha be used in combination with Juxtapid (lomitapide)?**
CONTINUATION OF THERAPY	
□ **Yes** □ **No**	**Is the patient continuing a low-fat diet and exercise regimen?**
□ **Yes** □ **No**	**Will medical records (e.g. chart notes, laboratory values) documenting the patient has low density lipoprotein cholesterol (LDL-C) reduction while on Repatha therapy be submitted?** *DOCUMENTATION REQUIRED*
□ **Yes** □ **No**	**For atherosclerotic cardiovascular disease or heterozygous familial hypercholesterolemia, does the patient continue to receive a statin at a maximally tolerated dose (unless patient has documented inability to take statins)?**
□ **Yes** □ **No**	**For homozygous familial hypercholesterolemia (HoFH), does the patient continue to receive other lipid-lowering therapy (e.g., statin, LDL apheresis)?**

Provider Signature: _____ **Date:** _____