



2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Repatha - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Form with fields for Patient Name, Prescriber Name, Member Number, Date of Birth, Line of Business, Address, City, State ZIP, Primary Phone, Fax, Phone, Office Contact, NPI, State Lic ID, and Specialty/facility name.

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Form with fields for Drug Name, Strength, and Directions / SIG.

Please attach any pertinent medical history including labs and information for this member that may support approval. Please answer the following questions and sign.

Q1. Is this a request for a continuation of therapy? If yes, go to 2. If no, go to 3.

Yes No

Q2. Has an updated lipid profile been attached?

Yes No

Q3. Does the patient have a diagnosis of Homozygous Familial Hypercholesterolemia as defined by one of the following? Please attach documentation.

- a. Genetic confirmation of 2 mutant alleles in the LDL receptor, Apo B- 100 or PCSK9 gene
b. Untreated LDL-C greater than 500 mg/dl
c. Treated LDL-C greater than or equal to 300 mg/dl with cutaneous or tendonous xanthoma before the age of 10
d. Untreated LDL-C levels consistent with heterozygous familial hypercholesterolemia in both parents (greater than 190 mg/dl)

Yes No

Q4. Is the patient 10 years of age or older?

Yes No

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Patient Name:	Prescriber Name:
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Q5. Is the patient being prescribed 420 mg once a month?

Yes

No

Q6. Does the patient of a diagnosis of heterozygous familial hypercholesterolemia (HeFH) as defined by one of the following? Please attach documentation.

a. Genetic confirmation of a mutation in the LDL receptor, Apo B- 100 or PCSK9

b. Dutch Lipid Network Criteria with a score greater than 6 points

Yes

No

Q7. Is the patient 10 years of age or older?

Yes

No

Q8. Does the patient have primary hyperlipidemia or clinical atherosclerotic cardiovascular disease (ASCVD)? Please attach documentation

Yes

No

Q9. Is the patient 18 years of age or older?

Yes

No

Q10. Has the patient had a prior treatment history with at least one high intensity statin therapy (atorvastatin 40 mg or 80 mg or rosuvastatin 20mg or 40 mg) with failure to reach target LDL-C levels?

Yes

No

Q11. Has the patient experienced statin-associated side effects? Please attach documentation.

Yes

No

Q12. Does the patient have a condition that would be considered a contraindication to statin therapy, including active liver disease, or persistent elevation of serum transaminases?

Yes

No



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Q13. Have baseline labs (lipid profile) been attached?

Yes

No

Q14. Requested Duration:

12 Months

Other

Q15. Additional Information:

Prescriber Signature

Date

2024 Medicare Prior Authorization Request