Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Repatha

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners 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.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid		
□ CHIP	City, State ZIP:	
	Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

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 the prescribing physician a specialist (cardiologist, endocrinologist, or lipidologist) or being prescribed in consultation with a specialist?

☐ Yes ☐ No

Q2. 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, ApoB- 100 or PCSK9 gene OR B . Untreated LDL-C greater than 500 mg/dl or treated LDL-C greater than or equal to 300 mg/dl with cutaneous or tendonous xanthoma before the age of 10 or untreated LDL-C levels consistent with heterozygous familial hypercholesterolemia in both parents (greater than 190 mg/dl)?Please attach documentation.

☐ Yes ☐ No

Q3. Is the patient 13 years of age or older?

☐ Yes ☐ No

Q4. Is the dose being prescribed 420 mg once a month?

☐ Yes ☐ No

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q6. Does the patient of a diagnosis of heterozygous familial hypercholesterolemia (HeFH) as defined by one of the

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following; A.Genetic confirmation of a mutation in the LDL receptor, ApoB- 100 or PCSK9 OR B.WHO/Dutch Lipid Network Criteria with a score greater than 6 points? Please attach documentation

☐ Yes ☐ No

Q7. Does the patient have clinical atherosclerotic cardiovascular disease (ASCVD)? Please attach documentation.

☐ Yes ☐ No

Q8. Is the dosing being prescribed 140 mg twice a month or 420mg once a month?

☐ Yes ☐ No

Q9. Has the patient had a prior treatment history with maximally tolerated dose of high intensity statin therapy (atorvastatin 40 mg or 80 mg or rosuvastatin 20 or 40 mg) and ezetimibe for at least three continuous months with failure to reach target LDL-C (70 mg/dl for clinical ACSVD and 100 mg/dl for HeFH)? Please attach documentation of trial with statin and labs (including lipid profile).

☐ Yes ☐ No

Q10. If the patient failed to reach target LDL-C, has adherence to maximally tolerated statin been assessed?

☐ Yes ☐ No

Q11. Is the patient statin intolerant? Please attach documentation detailing intolerance.

☐ Yes ☐ No

Q12. Has the National Lipid Association, the American College of Cardiology or the American Heart Association Guidelines guidance strategies for statin intolerance been used to manage the patient with statin intolerance?

☐ Yes ☐ No

Q13. Has the patient been diagnosed with rhabdomyolysis associated with statin use supported by documentation of acute neuromuscular illness or dark urine AND acute elevation in creatine kinase (usually >5,000 IU/L or 5 times the upper limit of normal). Please attach documentation.

☐ Yes ☐ No

Q14. 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

Q15. Have baseline labs (lipid profile and liver function tests) been attached?

☐ Yes ☐ No

Q16. Will the patient be continued on treatment with maximally tolerated statin and diet while being treated with a Repatha®?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q17. Requested Duration:

☐ 3 months

Q18. Additional Information:

Prescriber Signature

Date

Updated 2018