FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR LIPOTROPICS, PROPROTEIN CONVERTASE SUBTILISIN / KEXIN TYPE 9 (PCSK9) INHIBITORS

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Lipotropics, Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) Inhibitors Instructions, F-02505A. Prescribers may refer to the Forms page of the ForwardHealth Portal at www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization Drug Attachment for Lipotropics, PCSK9 Inhibitors form signed and dated by the prescriber before submitting a prior authorization (PA) request on the Portal, by fax, or by mail. Prescribers and pharmacy providers may call Provider Services at 800-947-9627 with questions.

SECTION I – MEMBER INFORMATION

1. Name – Member (Last, First, Middle Initial)

2. Member ID Number

3. Date of Birth – Member

SECTION II – PRESCRIPTION INFORMATION

4. Drug Name

5. Drug Strength

6. Date Prescription Written

7. Refills

8. Directions for Use

9. Name – Prescriber

10. Address – Prescriber (Street, City, State, Zip+4 Code)

11. Phone Number – Prescriber

12. National Provider Identifier – Prescriber

SECTION III – CLINICAL INFORMATION – ALL PA REQUESTS

13. Diagnosis Code and Description

14. Indicate the member's current low-density lipoprotein (LDL).

_____ Mg/dL

15. Date Member's LDL Measured

_____ / _____ / _____
Month Day Year

SECTION IV – CLINICAL INFORMATION – INITIAL PA REQUESTS ONLY

Note: Supporting clinical information and a copy of the member's current medical records must be submitted with initial PA requests. The supporting clinical information and medical records must include the following:

- Evidence that the member has heterozygous familial hypercholesterolemia (HeFH), homozygous familial hypercholesterolemia (HoFH), or clinical atherosclerotic cardiovascular disease (ASCVD)
- A current lipid panel lab report (HeFH and HoFH only)
- Documentation of the member's current and previous lipid lowering drug therapies, including the following for each trial:
  - Drug name(s) and dosage
  - Dates taken
  - Lipid panel report prior to and during drug therapy (including dates taken) (HeFH and HoFH only)
  - Reasons for discontinuation if drug therapy was discontinued

16. Indicate which of the following medical conditions the PCSK9 inhibitor drug is being prescribed to treat.

❑ HeFH
Clinical documentation must support a **definitive** diagnosis of HeFH using either World Health Organization criteria (Dutch Lipid Clinic Network clinical criteria with a score greater than eight) or Simon Broome diagnostic criteria.

❑ HoFH
Genetic testing or clinical confirmation must be submitted.

❑ Clinical ASCVD
Clinical documentation must provide evidence of **at least one** of the following (check all that apply):

- ❑ The member has coronary artery disease, which is supported by a history of myocardial infarction (heart attack), coronary revascularization, or angina pectoris.
- ❑ The member has a history of stroke.
- ❑ The member has symptomatic peripheral arterial disease as evidenced by **one** of the following (check all that apply):
  - ❑ Intermittent claudication with an ankle-brachial index of less than or equal to 0.9
  - ❑ Peripheral arterial revascularization procedure or amputation due to atherosclerotic disease

❑ Other _____

17. Document the member's current and previous lipid lowering drug therapies including the following for each trial:
    - Drug name(s) and dosage
    - Dates taken
    - Lipid panel report prior to and during drug therapy, including dates taken (HeFH and HoFH only)
    - Reasons for discontinuation if drug therapy was discontinued

SECTION V – CLINICAL INFORMATION – RENEWAL PA REQUESTS ONLY

Note: A copy of the member's current lipid panel (within the past 30 days) must be submitted with HeFH and HoFH renewal PA requests.

18. Document the member's lipid lowering drug therapies. Include the name, dose, and dosing regimen for each drug.

Drug Name _____

Dose _____ Dose Regimen _____

Drug Name _____

Dose _____ Dose Regimen _____

Drug Name _____

Dose _____ Dose Regimen _____

SECTION VI – AUTHORIZED SIGNATURE

19. **SIGNATURE –** Prescriber	20. Date Signed

SECTION VII – ADDITIONAL INFORMATION

21. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.

Reset Form