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

□ 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.

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS:

- What is the patient's diagnosis? (Check which apply)

□ Heterozygous familial hypercholesterolemia (HeFH) □ Atherosclerotic cardiovascular disease (ASCVD)

□ Other, list diagnosis: _____

- 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? □ Yes □ No

(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- 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])? □ Yes □ No

If yes, list intolerance: _____

- 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? □ Yes □ No

(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- 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? □ Yes □ No

(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- Is the patient unable to tolerate low- or moderate-, and high-intensity statins as evidenced by one of the following: (check which applies) □ Yes □ No

□ 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)***

- Is there submission of medical records (e.g., chart notes, laboratory values) documenting either of the following: (check which applies) □ Yes □ No

□ 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

(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- 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? □ Yes □ No

(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

Requests for HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HeFH):

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

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Member First name:	Member Last name:	Member DOB:

- Does the patient have <u>one</u> of the following: □ Yes □ No

□ 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

- Is there submission of medical records (e.g., chart notes, laboratory values) documenting <u>any</u> of the following: □ Yes □ No (check which apply)

□ Functional mutation in LDL, apoB, or PCSK9 gene*
□ Tendinous xanthomata
□ Arcus cornealis before age 45

<u>Requests for ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD):</u>

- Is ASCVD confirmed by <u>one</u> of the following: □ Yes □ No (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

<u>Requests for CONTINUATION OF THERAPY:</u>

- Does the patient continue to receive a statin at the maximally tolerated dose (unless the patient has documented inability to take statins)? □ Yes □ No
If yes, list dose or reason: _____

- Is the patient continuing a low-fat diet and exercise regimen? □ Yes □ No

- Is Praluent prescribed by <u>one</u> of the following: □ Yes □ No (check which apply)

□ Cardiologist □ Endocrinologist □ Lipid specialist

- Is there submission of medical records (e.g., chart notes, laboratory values) documenting LDL-C reduction while on Praluent therapy? □ Yes □ No
If yes, list LDL-C value and date: _____

- Will Praluent be used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor? □ Yes □ No (If yes, complete Section D above with medication information, including dose and date of trial)

Provider Signature: _____ Date: _____