Health Partners Medicare

2023 PRIOR AUTHORIZATION REQUEST FORM

Repatha - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

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:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ 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.

Drug Name:	
Strength:	
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 Repatha being prescribed by or in consultation with an appropriate specialist (cardiologist, endocrinologist, or lipidologist)?

☐ Yes ☐ No

Q2. Does the patient have the diagnosis of homozygous familial hypercholesterolemia as defined by one of the following?
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

Must attach documentation.

☐ Yes ☐ No

Q3. Is the patient 10 years of age or older?

☐ Yes ☐ No

Q4. Is the patient being prescribed 420 mg once per month?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. 5. Does the patient of a diagnosis of heterozygous familial hypercholesterolemia (HeFH) as defined by one of the following? Please attach documentation
A.) Genetic confirmation
B.) Dutch Lipid Network Criteria with a score greater than 6 points

☐ Yes ☐ No

Q6. Is the patient 10 years of age or older?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q8. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q9. 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) for at least three continuous months with failure to reach target LDL-C levels?

☐ Yes ☐ No

Q10. Has the patient experienced statin-associated side effects?
Must attach documentation.

☐ Yes ☐ No

Q11. 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

Q12. Have either baseline labs or post-treatment labs (lipid profile) been attached?

☐ Yes ☐ No

Q13. Is this a request for a continuation of therapy?

☐ Yes ☐ No

Q14. Additional Information:

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Patient Name:	**Prescriber Name:**

Q15. Duration:

☐ Initial Request - 6 months
☐ Continuation Request - 12 months
☐ Other:

Prescriber Signature

Date

2023 Medicare Prior Authorization Request