SoonerCare
Oklahoma Health Care Authority

State of Oklahoma: Oklahoma Health Care Authority
PCSK9 Inhibitor Prior Authorization Form

Pharmacy Section

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____
Pharmacy NPI: _____ ***Pharmacy Phone:*** _____ ***Pharmacy Fax:*** _____
Pharmacy Name: _____ ***Pharmacist Name:*** _____
Prescriber NPI: _____ ***Prescriber Name:*** _____ ***Specialty:*** _____
Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Drug Name/Strength:*** _____
NDC: _____ ***Regimen:*** _____ ***Fill Quantity:*** _____ ***Day Supply:*** _____
Has member been trained on proper administration and storage of this medication? ___Yes ___ No
Pharmacist Signature: _____ **Date:** _____

Prescriber Section

1. Please indicate member's diagnosis:

☐ Heterozygous familial hypercholesterolemia (HeFH) confirmed by one of the following:
- ☐ Definite HeFH confirmed using the Simon Broome or the Dutch Lipid Network diagnostic criteria
  - a) Please list factors leading to definite diagnosis of HeFH via Simon Broome Register criteria: _____ or
  - b) Dutch Lipid Network criteria score: _____
- ☐ Documented functional mutation(s) in the LDL receptor gene or other HeFH genes via genetic testing**

☐ Homozygous familial hypercholesterolemia (HoFH) confirmed by one of the following:
- ☐ Untreated total cholesterol >500mg/dL and at least one of the following:
  - ☐ Documented evidence of definite HeFH in both parents; or
  - ☐ Presence of tendinous/cutaneous xanthoma prior to age 10 years
- ☐ Documented functional mutation(s) in both LDL receptor alleles via genetic testing**

*(**Please note if this option is selected genetic testing results must be submitted with the prior authorization request)*

☐ Clinical atherosclerotic cardiovascular disease (CVD) defined by the presence of one of the following criteria:
- ☐ High CV risk confirmed by Framingham risk score. Please provide both the Framingham risk score and supporting diagnoses/conditions signifying this risk level: _____ _____ or
- ☐ Documented history of Coronary Heart Disease (CHD). Please provide supporting diagnoses/conditions and dates of occurrence signifying history of CHD: _____

☐ Primary hyperlipidemia

☐ Established CVD (to reduce the risk of myocardial infarction, stroke, and coronary revascularization). Please provide supporting diagnoses/conditions and dates of occurrence signifying established CVD: _____ _____

2. Please specify the member's current statin therapy:
   a) Drug Name: _____ Dose: _____ Duration of Treatment: _____
   b) Has member been adherent to high-dose statin therapy for at least 12 continuous weeks? Yes___ No___
   SoonerCare claims analysis will be conducted to verify adherence compliance.
   a) If member is statin intolerant due to myalgia, provide creatine kinase (CK) labs verifying rhabdomyolysis.
   Members with myalgia not confirmed by CK labs must have at least 2 trials of lower dose statin therapy or failure of intermittent dosing.
3. Member's baseline LDL-C: _____ Current LDL-C: _____ Goal LDL-C: _____
4. How will this medication be used? _____ Monotherapy _____ Adjunct to statin therapy, diet, and exercise

Initial approvals will be for the duration of 3 months. Continued authorization will require recent LDL-C levels to demonstrate effectiveness and compliance will be checked at that time and every 6 months thereafter.

Prescriber Signature: _____ **Date:** _____
Has the member been counseled on proper administration and storage of PCSK9 therapy? Yes___ No___

Member (Patient) Section

Please have the member initial after each line, fill in all blanks, and sign at the bottom.

1. I understand this medicine must be injected. **Initials:_____**
2. I understand I must give myself a shot every _____ week(s). **Initials: _____**
3. I understand this medication must be kept in the refrigerator. **Initials: _____**
4. I will not leave this medication in the car or anywhere it would get hot. **Initials: _____**
5. I understand this medication will not be replaced if I leave it out of the refrigerator. **Initials: _____**

Member Signature: _____ **Date:** _____

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

OHCA Approved - 12/6/2017