



2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Repatha

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health 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.

Form with fields for Patient Name, Prescriber Name, Member Number, Date of Birth, Line of Business, Address, City, State ZIP, Primary Phone, Fax, Phone, Office Contact, NPI, State Lic ID, and Specialty/facility name.

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Form with fields for Drug Name, Strength, and 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 this a request for a continuation of therapy?

Yes checkbox

No checkbox

Q2. Has an updated lipid profile been attached?

Yes checkbox

No checkbox

Q3. 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, 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 (greater than 190 mg/dl)

Yes checkbox

No checkbox

Q4. Is the patient 10 years of age or older?



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| | |
|--|-----------------------------|
| Patient Name: | Prescriber Name: |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Q5. Is the patient being prescribed 420 mg once a month? | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Q6. Does the patient of a diagnosis of heterozygous familial hypercholesterolemia (HeFH) as defined by one of the following? Please attach documentation | |
| a. Genetic confirmation of a mutation in the LDL receptor, Apo B- 100 or PCSK9 | |
| b. Dutch Lipid Network Criteria with a score greater than 6 points | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Q7. Does the patient have primary hyperlipidemia or clinical atherosclerotic cardiovascular disease (ASCVD)? Please attach documentation. | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Q8. Is the patient 18 years of age or older? | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> 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) with failure to reach target LDL-C levels? | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Q10. Has the patient experienced statin-associated side effects? Please attach documentation. | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> 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? | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |



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Form fields for Patient Name and Prescriber Name

Q12. Have baseline labs (lipid profile) been attached?

Yes checkbox

No checkbox

Q13. Additional Information:

Prescriber Signature

Date

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