HYPERLIPIDEMIA AGENTS
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

ONLY the prescriber may complete and fax this form. This form is for prospective, concurrent, and retrospective reviews.

Incomplete forms will be returned for additional information. The following documentation is required for prior authorization consideration. For formulary information and to download additional forms, please visit https://www.bcbstx.com/provider/medicaid/pharmacy/rx-prior-auth

PATIENT AND INSURANCE INFORMATION **Today's Date:** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):
Patient Address:	City, State, Zip:	Patient Telephone:	
BCBSTX ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis (please check one of the following):

☐ Diagnosis of Heterozygous Familial Hypercholesteremia Date of diagnosis:_____

☐ Clinical Atherosclerotic Cardiovascular Disease Date of diagnosis:_____

☐ Diagnosis of Homozygous Familial Hypercholesteremia Date of diagnosis:_____

☐ Diagnosis of Primary Hyperlipidemia Date of diagnosis:_____

☐ Other, please specify ICD code plus description _____ Date of diagnosis:_____

Medication Requested: Strength:

Dosing Schedule: Quantity per Month:

Please indicate PSCK9 Treatment Status: ☐ Initial ☐ Continuation; Date of treatment initiation: _____

☐ Expedited/Urgent Review Requested: By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Signature of prescriber or prescriber's designee: _____ Date: _____

Section 1. Drug Treatment History (complete as applicable):

Drug	**Last prescribed dose**	**Start date** (mm/dd/ccyy)	**End date*** (if applicable) (mm/dd/ccyy or N/A)
☐ atorvastatin			
☐ ezetimibe			
☐ rosuvastatin			
☐ other (please specify):			
☐ other (please specify):			
☐ other (please specify):			

**For current therapy, indicate "N/A" for "End date".*

Please continue to next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):

1. Is the patient currently treated with the requested medication? ☐ Yes ☐ No
   If yes, when was treatment with the requested medication started: _____
   If yes, has the patient shown clinical response since initiating therapy? ☐ Yes ☐ No
2. Is the patient currently pregnant? ☐ Yes ☐ No
3. Does the patient have a diagnosis of moderate or severe hepatic impairment in the last 365 days? ☐ Yes ☐ No
4. Has the patient had at least 90 consecutive days of statin therapy at the maximally tolerated dose prior to initiation of the requested agent? ☐ Yes ☐ No
5. Does the patient have an intolerance or contraindication to statin therapy? ☐ Yes ☐ No
6. Is the patient at an increased risk of adverse cardiovascular events (i.e., cardiovascular death, myocardial infarction, stroke, or coronary revascularization)? ☐ Yes ☐ No

Section 2. Laboratory Information:

LDL-C prior to initiation of PCSK9 treatment: _____ mg/dL	Date level obtained: _____ (for first time requests, level must be from previous 60 days)
Current LDL-C: _____ mg/dL*	Date level obtained: _____ (level must be from previous 60 days)

*Required for renewal requests only. Must have at least a 50% reduction in LDL-C compared to LDL-C level prior to PCSK9 treatment initiation for patients with HeFH, at least a 30% reduction in LDL-C for patients with HoFH, 10% decrease for patients taking Nexletol and 15% decrease for patients taking Nexlizet for renewal approval.

By signing below, I, the prescriber, certify that the information provided above is verifiable and accurate to the best of my knowledge.

Prescriber Signature: _____ Date: _____

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.
Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Please fax or mail this form to:
Prime Therapeutics LLC, Clinical Review Department
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Eagan, Minnesota 55121

TOLL FREE
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