PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Praluent - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Praluent - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Praluent (alirocumab)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Does the patient have a diagnosis of hypercholesterolemia? Y N

[If no, skip to question 3.]

2. Does the patient have a diagnosis of heterozygous familial hypercholesterolemia (HeFH) documented by medical records and laboratory LDL-C values greater than 190mg/dl prior to statin therapy? Y N

NOTE: Submission of medical records is required.

[If yes, skip to question 5.]

	[If no, no further questions.]	
3.	Is the requested drug being prescribed to prevent a cardiovascular event?	Y N
	[If no, no further questions.]	
4.	Does the patient have a documented history of clinical atherosclerotic cardiovascular disease (ASCVD) evidenced by at least one of the following: acute coronary syndromes (ACS), history of myocardial infarction (MI), stable or unstable angina, coronary or other arterial revascularization, stroke, or transient ischemic attack (TIA), peripheral arterial disease presumed to be of atherosclerotic origin?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
5.	Is the patient 18 years of age or older?	Y N
	[If no, no further questions.]	
6.	Has the patient failed treatment with one statin regimen used for at least 90 days, consisting of a high potency statin at the maximum tolerated dose (i.e. atorvastatin 40 or higher, or rosuvastatin 20mg or higher) in combination with Zetia (ezetimibe), despite optimal compliance with regimen?	Y N
	NOTE: Treatment failure is define as: less than 50 percent reduction LDL-C for individuals where initial LDL-C is known, LDL-C remains greater than or equal to 70mg/dl for individuals where initial LDL-C is unknown and patient has documented CVD, or LDL-C remains greater than or equal to 100mg/dl and patient has no documented history of CVD) \ NOTE: Submission of medical records is required.	
	[If yes, skip to question 9.]	
7.	Does the patient have a condition that is a contraindication to statin therapy including active liver disease or unexplained persistent elevation of serum transaminases (greater than 3 times the upper limit of normal per laboratory reference range)?	Y N
	NOTE: Submission of medical records is required.	
	[If yes, skip to question 9.]	
8.	Does the patient have statin intolerance (defined by the National Lipid Association Statin Intolerance Panel and includes all of the following: A) inability to tolerate at least 2 statins, with at least one started at the lowest starting daily dose, B) statin dose reduction is attempted for symptom and biomarker abnormality resolution, rather than discontinuation of statin therapy altogether, C) intolerable symptoms or abnormal biomarker changes are reversible upon statin discontinuation, but reproducible by re-challenge of statins, if clinically appropriate?	Y N
	NOTES: Statin re-challenge may be appropriate for individuals with all of the following: symptomatic; AND creatine kinase is less than 4 times the upper limit of	

normal per laboratory reference range; AND AST/ALT are less than 3 times the upper limit of normal per laboratory reference range. Symptoms or biomarker abnormalities are not attributable to established predispositions or conditions recognized to increase the risk of statin intolerance, such as: hypothyroidism, drug interactions, concurrent illness, significant changes in physical activity/exercise, or underlying muscle disease. \ NOTE: Submission of medical records is required.	
[If no, no further questions.]	
9. Will the requested drug be used in combination with a statin used at the maximum tolerated dose unless statin contraindication or intolerance exists?	Y N
[If no, no further questions.]	
10. Has the patient received comprehensive counseling regarding appropriate diet and lifestyle modifications?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
11. Is the requested drug being prescribed by a cardiologist, endocrinologist or lipid specialist?	Y N
[If no, no further questions.]	
12. Is the quantity being requested within FDA approved labeling?	Y N
[If no, no further questions.]	
13. Will the patient use evolocumab (Repatha) and alirocumab (Praluent) concurrently?	Y N
[If yes, no further questions.]	
14. Will the requested drug be used concurrently with Juxtapid (lomitapide) or Kynamro (mipomersen)?	Y N
[If yes, no further questions.]	
15. Is the request for a continuation of therapy?	Y N
[If no, no further questions.]	
16. Has adherence with therapy resulted in a greater than 45 percent reduction of LDL-C from baseline?	Y N
NOTE: Submission of medical records to support LDL reduction is required.	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date