Prior Authorization Request Form for
alirocumab **(Praluent)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the request for renewal of therapy? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Praluent*	☐ Yes Skip to question 21 on page 2	☐ No Proceed to question 2
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question 3	☐ No **STOP** Coverage not approved
3. Is the requested medication being prescribed by a cardiologist, lipidologist, or endocrinologist?	☐ Yes Proceed to question 4	☐ No **STOP** Coverage not approved
4. Does the patient have a diagnosis of either heterozygous familial hypercholesterolemia (HeFH) or clinical atherosclerotic cardiovascular disease (ASCVD)?	☐ Yes Proceed to question 5	☐ No **STOP** Coverage not approved
5. Has the patient tried Repatha (evolocumab)?	☐ Yes Proceed to question 6	☐ No **STOP** Coverage not approved
6. Will the patient be on concurrent statin therapy at a maximal tolerated dose while on the requested medication?	☐ Yes **SKIP** to question **16** *on next page*	☐ No Proceed to question 7
7. Has the patient experienced intolerable and persistent (for longer than 2 weeks) muscle symptoms (muscle pain, weakness, cramps) while on statin therapy?	☐ Yes Proceed to question 8	☐ No **SKIP** to question **10** *on next page*
8. Has the patient undergone at least 2 trials of statin rechallenges with reappearance of muscle symptoms? -- NOTE: that is, the patient has had 2 trials of statins with muscle symptoms	☐ Yes **SKIP** to question **11** *on next page*	☐ No Proceed to question 9
9. Has the patient had a creatine kinase (CK) level greater than 10 times the upper limit of normal OR rhabdomyolysis with CK greater than 10,000 international units per liter (IU/L) that is unrelated to statin use?	☐ Yes **SKIP** to question **11** *on next page*	☐ No Proceed to question 10 *on next page*

Continue to next page

10. Does the patient have a contraindication to the use of a statin? -- NOTE: Please select the option that best applies to this patient's condition.	☐ Active Liver Disease (including unexplained persistent elevations in hepatic transaminase levels) - **Proceed** to question 11 ☐ Hypersensitivity - **Proceed** to question 11 ☐ Pregnancy - **Proceed** to question 11 ☐ Nursing mothers - **Proceed** to question 11 ☐ None of the above **– STOP – Coverage not approved**		
11. What is the indication or diagnosis?	☐ Heterozygous familial hypercholesterolemia (HeFH) - **SKIP** to question **20** ☐ Clinical atherosclerotic cardiovascular disease (ASCVD) - Proceed to question 12		
12. Has the patient tried both atorvastatin (Lipitor) at a dose of 40 mg to 80 mg AND rosuvastatin (Crestor) at a dose of 20 mg to 40 mg for at least 4 to 6 weeks each?		☐ Yes **SKIP** to question **15**	☐ No Proceed to question 13
13. Has the patient tried any statin at a maximally tolerated dose in combination with ezetimibe (Zetia) for at least 4 to 6 weeks?		☐ Yes **SKIP** to question **15**	☐ No Proceed to question 14
14. Has the patient tried ezetimibe (Zetia) either as monotherapy (alone) or with other lipid-lowering therapy for at least 4 to 6 week? -- NOTE: Other lipid-lowering therapy such as fenofibrate, niacin, or a bile acid sequestrant.		☐ Yes Proceed to question 15	☐ No **STOP** Coverage not approved
15. Does the patient have an LDL level greater than 100 mg/dL despite lipid-lowering therapy at maximal tolerated doses?		☐ Yes **SKIP** to question **20**	☐ No **STOP** Coverage not approved
16. What is the indication or diagnosis?	☐ Heterozygous familial hypercholesterolemia (HeFH) - **SKIP** to question **20** ☐ Clinical atherosclerotic cardiovascular disease (ASCVD) - Proceed to question 17		
17. Has the patient tried both atorvastatin (Lipitor) at a dose of 40 mg to 80 mg AND rosuvastatin (Crestor) at a dose of 20 mg to 40 mg for at least 4 to 6 weeks each?		☐ Yes **SKIP** to question **19**	☐ No Proceed to question 18
18. Has the patient tried any statin at a maximally tolerated dose in combination with ezetimibe (Zetia) for at least 4 to 6 weeks?		☐ Yes Proceed to question 19	☐ No **STOP** Coverage not approved
19. Does the patient have an LDL level greater than 100 mg/dL despite lipid-lowering therapy at maximal tolerated doses?		☐ Yes Proceed to question 20	☐ No **STOP** Coverage not approved
20. Is the patient pregnant or breastfeeding?		☐ Yes **STOP** Coverage not approved	☐ No Proceed to question 24
21. Does the patient have a documented positive response to therapy with an LDL less than 70 mg/dL (or an LDL decrease greater than 30% from baseline)?		☐ Yes Proceed to question 22	☐ No **STOP** Coverage not approved
22. Does the patient have documented adherence to therapy?		☐ Yes Proceed to question 23	☐ No **STOP** Coverage not approved
23. Is this renewal request being submitted by a cardiologist, lipidologist, or endocrinologist OR by a primary care provider in consultation with the initial prescribing cardiologist, endocrinologist, or lipidologist?		☐ Yes Proceed to question 24	☐ No **STOP** Coverage not approved
24. What dose is being prescribed?	☐ 75 mg every 2 weeks – Sign and date on page 3 ☐ 150 mg every 2 weeks – Sign and date on page 3 ☐ Other - **Coverage not approved**		

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Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[10 May 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: