Prior Authorization Request Form for
evolocumab **(Repatha)**

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 Repatha*	☐ Yes Proceed to question 8	☐ No Proceed to question 2
2. What is the indication or diagnosis?	☐ Homozygous familial hypercholesterolemia (HoFH) – Proceed to question 3 ☐ Heterozygous familial hypercholesterolemia (HeFH) – **SKIP** to question **14** ☐ Clinical atherosclerotic cardiovascular disease (ASCVD) – **SKIP** to question **14** ☐ Other – **STOP** - **Coverage not approved**	
3. Is the patient 13 years of age or older?	☐ Yes Proceed to question 4	☐ No **STOP** Coverage not approved
4. Is the requested medication being prescribed by a cardiologist, lipidologist, or endocrinologist?	☐ Yes Proceed to question 5	☐ No **STOP** Coverage not approved
5. Is the patient receiving other LDL-lowering therapies (for example, a statin, ezetimibe [Zetia], LDL apheresis)?	☐ Yes Proceed to question 6	☐ No **STOP** Coverage not approved
6. Does the patient require additional lowering of LDL cholesterol?	☐ Yes Proceed to question 7	☐ No **STOP** Coverage not approved
7. Is the patient pregnant or breastfeeding?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question 12
8. Does the patient 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 9	☐ No **STOP** Coverage not approved
9. Does the patient have documented adherence to therapy?	☐ Yes Proceed to question 10	☐ No **STOP** Coverage not approved

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10. 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 11	☐ No **STOP** Coverage not approved
11. What is the indication or diagnosis?	☐ Homozygous familial hypercholesterolemia (HoFH) – Proceed to question **12** ☐ Heterozygous familial hypercholesterolemia (HeFH) – **SKIP** to question **13** ☐ Clinical atherosclerotic cardiovascular disease (ASCVD) – **SKIP** to question **13** ☐ Other – **STOP** - **Coverage not approved**	
12. What dose is being prescribed?	☐ 420 mg every 4 weeks – Sign and date on page 3 ☐ Other – **STOP** - **Coverage not approved**	
13. What dose is being prescribed?	☐ 140 mg every 2 weeks – Sign and date on page 3 ☐ 420 mg every 4 weeks as one Pushtronex injection – Sign and date on page 3 ☐ 420 mg every 4 weeks as three 140 mg syringes/autoinjectors – **STOP - Coverage not approved** ☐ Other – **STOP - Coverage not approved**	
14. Is the requested medication being prescribed by a cardiologist, lipidologist, or endocrinologist?	☐ Yes Proceed to question 15	☐ No **STOP** Coverage not approved
15. Is the patient 18 years of age or older?	☐ Yes Proceed to question 16	☐ No **STOP** Coverage not approved
16. Will the patient be on concurrent statin therapy at a maximal tolerated dose while on the requested medication?	☐ Yes **SKIP** to question 26	☐ No Proceed to question 17
17. 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 18	☐ No **Skip** to question 20
18. 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 **21**	☐ No Proceed to question 19
19. 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 **21**	☐ No Proceed to question 20
20. 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 21 ☐ Hypersensitivity - **Proceed** to question 21 ☐ Pregnancy - **Proceed** to question 21 ☐ Nursing mothers - **Proceed** to question 21 ☐ None of the above – **STOP – Coverage not approved**	
21. What is the indication or diagnosis?	☐ Heterozygous familial hypercholesterolemia (HeFH) - **SKIP** to question **30** ☐ Clinical atherosclerotic cardiovascular disease (ASCVD) - Proceed to question 22	
22. 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 **25**	☐ No Proceed to question 23

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23. 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 **25**	☐ No Proceed to question 24
24. Has the patient tried ezetimibe (Zetia) either as monotherapy (alone) or with other lipid-lowering therapy for at least 4 to 6 weeks? -- NOTE: Other lipid-lowering therapy such as fenofibrate, niacin, or a bile acid sequestrant.	☐ Yes Proceed to question 25	☐ No **STOP** Coverage not approved
25. Does the patient have an LDL level greater than 100 mg/dL despite lipid-lowering therapy at maximal tolerated doses?	☐ Yes **SKIP** to question **30**	☐ No **STOP** Coverage not approved
26. What is the indication or diagnosis?	☐ Heterozygous familial hypercholesterolemia (HeFH) - **SKIP** to question **30** ☐ Clinical atherosclerotic cardiovascular disease (ASCVD) - Proceed to question 27	
27. 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** 29	☐ No Proceed to question 28
28. 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 29**	☐ No **STOP** Coverage not approved
29. Does the patient have an LDL level greater than 100 mg/dL despite lipid-lowering therapy at maximal tolerated doses?	☐ Yes **Proceed to question 30**	☐ No **STOP** Coverage not approved
30. Is the patient pregnant or breastfeeding?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 31**
31. What dose is being prescribed?	☐ 140 mg every 2 weeks – Sign and date below ☐ 420 mg every 4 weeks as one Pushtronex injection – Sign and date below ☐ 420 mg every 4 weeks as three 140 mg syringes/autoinjectors – **Coverage not approved** ☐ **Other -** Coverage not approved	

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

_____ _____
Prescriber Signature Date

[7 June 2019]

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