

Member Name: _____ Member ID: _____ Member DOB: _____
 Drug Name: _____ Strength: _____ Directions: _____
 Physician Name: _____ Physician Phone #: _____ Specialty: _____
 Physician Fax #: _____ Pharmacy Name: _____ Pharmacy Phone: _____

Horizon NJ Health
Proprotein Convertase Subtilisin/kexin type 9(PCSK9) Modifiers – Medical Necessity Request
Complete pages 1 and 2 for Initial request and page 3 for Subsequent request

General Questions:

1. Is the member pregnant? **Yes** or **No**
2. Will the member be receiving another PCSK-9 modifier? **Yes** or **No**
3. Please provide the member's LDL-C levels (mg/dL)
 - a. Pretreatment LDL-C levels _____ mg/dL **Please fax over lab report or office notes confirming this level.*
 - b. Current (past 30 days) LDL-C levels _____ mg/dL date taken _____ **Please fax over lab report confirming this level.*
4. Has member tried any statins? **Yes** or **No**

If Yes,

| <i>Drug Name/Strength/Quantity per Day</i> | <i>Dates filled</i> | <i>Pharmacy Name/Phone Number</i> | <i>Discontinuation Reason (if applicable)</i> |
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If No, Can member try a high intensity Statin (i.e. rosuvastatin 20-40mg or atorvastatin 40-80mg) instead? **Yes** or **No**

If yes, please call the pharmacy, then return form to HNJJH

If no, please provide clinical reason why? _____

Please send in the documentation (such as copy of chart or lab data) regarding why member is not able to take and/or tolerate statins)

5. Will the member be receiving maximally tolerated statin with PCSK9-Modifier? **Yes** or **No**

If yes, please provide name and strength _____
 Dates filled _____
 Pharmacy name _____
 Pharmacy phone number _____

If No, please provide clinical reason why? _____
Please send in the documentation (such as copy of chart or lab data) regarding why member is not able to take and/or tolerate statins)

Physician office's signature* _____ **Print Name** _____

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____
Drug Name: _____ Strength: _____ Directions: _____
Physician Name: _____ Physician Phone #: _____ Specialty: _____
Physician Fax #: _____ Pharmacy Name: _____ Pharmacy Phone: _____

6. Is member currently receiving Ezetimibe (Zetia)? **Yes or No**

If yes, please provide dates filled _____

Pharmacy name _____

Pharmacy phone number and answer # 7 _____

If No, Can member try Zetia instead? **Yes or No**

If yes, please call the pharmacy, then return form to HNJH

If no, please provide clinical reason why? _____

Please send in the documentation (such as copy of chart or lab data) regarding why member is not able to take and/or tolerate Zetia)

7. Will the member be receiving Zetia with PCSK9-Modifier? **Yes or No**

If No, please provide clinical reason why? _____

Please send in the documentation (such as copy of chart or lab data) regarding why member is not able to take and/or tolerate Zetia)

Diagnosis Information (please indicate diagnosis and answer related questions):

Homozygous familial hypercholesterolemia (HoFH) **Note, if member also has Clinical Atherosclerotic Cardiovascular Disease (ASCVD), please also answer the ASCVD questions below

a. Will the member be receiving lomitapide (Juxtapid) or mipomersen (Kynamro) concurrently with this medication? **Yes or No**

b. How was the diagnosis confirmed (e.g., genetic tests, labs, symptoms)? _____

Please send in the documentation (such as copy of chart or lab data) confirming it

c. What other drugs/therapies will the member be receiving with Repatha? _____

Primary Hyperlipidemia including Heterozygous familial hypercholesterolemia (HeFH) **Note, if member also has Clinical Atherosclerotic Cardiovascular Disease (ASCVD), please also answer the ASCVD questions below

a. How was the diagnosis confirmed (e.g., genetic tests, labs, symptoms)? _____

Please send in the documentation (such as copy of chart or lab data) confirming it

Clinical Atherosclerotic Cardiovascular Disease (ASCVD)-Established cardiovascular disease **Please send documentation (such as copy of chart or lab data) confirming member's diagnosis.

a. What is the member's diagnosis? _____

Physician office's signature* _____ Print Name _____

*Form must be completed and signed by physician or licensed representative from the physician's office

Member Name: _____ Member ID: _____ Member DOB: _____
Drug Name: _____ Strength: _____ Directions: _____
Physician Name: _____ Physician Phone #: _____ Specialty: _____
Physician Fax #: _____ Pharmacy Name: _____ Pharmacy Phone: _____

Complete this page for Subsequent Request

General Questions:

1. Is the member pregnant? **Yes** or **No**
2. Will the member be receiving another PCSK-9 modifier? **Yes** or **No**
3. Will the member continue to receive the requested drug together with ezetimibe (Zetia)?
 Yes, please provide Dates filled _____
Pharmacy name: _____
Pharmacy phone number _____
 No – if not, why is the Zetia being discontinued: _____
Please send in the documentation (such as copy of chart or lab data) regarding why member is not able to take and/or tolerate Zetia)
4. Will the member continue to receive the requested drug together with a maximum intensity statin (atorvastatin 40-80mg, Rosuvastatin 20-40mg)?
 Yes, please provide name of medication names/strengths/quantity per day _____
Dates filled _____
Pharmacy name: _____
Pharmacy phone number: _____
 No - if not,
 - a. Why is the statin being discontinued _____
Please send in the documentation (such as copy of chart or lab data) regarding why member is not able to take and/or tolerate statins)
 - b. Will a lower statin dose be prescribed instead?
 Yes - Why is lower dose being use instead? _____
 No - if not, why not _____
Please send in the documentation (such as copy of chart or lab data) regarding why member is not able to take and/or tolerate statins)
5. Please provide the current LDL-C taken within the past 30 days and date taken.
- Level: _____ mg/dL Date Taken: _____ **Please fax over lab report confirming this level.*

Diagnosis Information (please indicate diagnosis and answer related questions):

- Homozygous familial hypercholesterolemia (HoFH)**
 - Will the member be receiving lomitapide (Juxtapid) or mipomersen (Kynamro) concurrently with this medication? **Yes** or **No**
 - What other drugs/therapeies will the member be receiving with Repatha? _____
- Primary Hyperlipidemia including Heterozygous familial hypercholesterolemia (HeFH)**
- Clinical Atherosclerotic Cardiovascular Disease (ASCVD)-Established cardiovascular disease**

Physician office's signature* _____ Print Name _____

*Form must be completed and signed by physician or licensed representative from the physician's office