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) Inhibitors – 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 inhibitor? **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,

Drug Name/Strength/Quantity per Day	***Dates filled***	***Pharmacy Name/Phone Number***	***Discontinuation Reason (if applicable)***

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 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 statins)

5. Will the member be receiving maximally tolerated statin with PCSK9-Inhibitor? **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-Inhibitor? **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 inhibitor? **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**