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. What is the specialty of the prescriber?
   □ Cardiologist □ Lipidologist □ Other _____
2. Is the member pregnant? Yes or No
3. Will the member be receiving another PCSK-9 inhibitor? Yes or No
4. Please provide the member's LDL-C levels
   a. Pretreatment LDL-C levels_____ ****Please fax over lab report or office notes confirming this level.***
   b. Current (past 30 days) LDL-C levels _____ date taken_____ ****Please fax over lab report confirming this level.***
5. Has member tried any statins? **Yes** or **No**
   If Yes, please provide name of medications_____
   Strength_____
   Dates filled_____
   Pharmacy name: _____
   Pharmacy phone number and answer #6: _____
   If No, Can member try high intensity Statin? (i.e. rosuvastatin 20-40mg or atorvastatin 40-80mg)? **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 statins*
6. Will the member be receiving maximally tolerated statin with PCSK9-Inhibitor? **Yes** or **No**
   If No, please provide clinical reason why? _____
7. Is member currently receiving Ezetimibe (Zetia) along with maximally tolerated statin for at least past 90 days? **Yes** or **No**
   If yes, please provide dates filled _____
   Pharmacy name_____
   Pharmacy phone number and answer # 9_____
   If No, Can member try Zetia? **Yes** or **No**
   If yes, please call the pharmacy, then return form to HNJH
   If no, please provide clinical reason why? _____
8. Will the member be receiving Zetia with PCSK9-Inhibitor? **Yes** or **No**
   If No, please provide clinical reason why? _____

**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: _____

## **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*

□ **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)** ***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**
   - □ **No –** if not, why is the Zetia being discontinued:_____

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 medications_____
     Dates filled_____
     Pharmacy name: _____
     Pharmacy phone number: _____
   - □ **No -** if not,
     a. Why is the statin being discontinued_____
     b. Will a lower statin dose be prescribed instead?
        - □ **Yes** - Why is lower dose being use instead?_____
        - □ **No -** if not, why not_____

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**

□ **Heterozygous familial hypercholesterolemia (HeFH)**

□ **Clinical Atherosclerotic Cardiovascular Disease (ASCVD)**

**Physician office's signature*_____ Print Name_____**
***Form must be completed and signed by physician or licensed representative from the physician's office**