STANDARDIZED ONE PAGE PHARMACY PRIOR AUTHORIZATION FORM

Mississippi Division of Medicaid, Pharmacy Prior Authorization Unit,
550 High St., Suite 1000, Jackson, MS 39201

MISSISSIPPI DIVISION OF MEDICAID

☐ Medicaid Fee for Service/Change Healthcare
Fax to: 1-877-537-0720 Ph: 1-877-537-0722
https://medicaid.ms.gov/providers/pharmacy/pharmacy-prior-authorization/

☐ Magnolia Health/Envolve Pharmacy Solutions
Fax to: 1-866-399-0929 Ph: 1-866-399-0928
https://www.magnoliahealthplan.com/providers/pharmacy.html

☐ UnitedHealthcare/OptumRx
Fax to: 1-866-940-7328 Ph: 1-800-310-6826
http://www.uhccommunityplan.com/health-professionals/ms/pharmacy-program.html

BENEFICIARY INFORMATION

Beneficiary ID: ____ ____ ____ - ____ ____ ____ - ____ ____ ____	**DOB: ____ ____ / ____ ____ / ____ ____ ____ ____**
Beneficiary Full Name:	

PRESCRIBER INFORMATION

Prescriber's NPI:	
Prescriber's Full Name:	**Phone:**
Prescriber's Address:	**FAX:**

PHARMACY INFORMATION

Pharmacy NPI:	
Pharmacy Name:	
Pharmacy Phone:	**Pharmacy FAX:**

CLINICAL INFORMATION

Requested PA Start Date:_____ Requested PA End Date:_____

Drug/Product Requested:_____ Strength:_____ Quantity:_____

Days Supply:_____ RX Refills:_____ Diagnosis or ICD-10 Code(s):_____

☐ **Hospital Discharge** ☐ **Additional Medical Justification Attached**

Medications received through coupons and/or samples are not acceptable as justification

PLEASE COMPLETE AND FAX DRUG SPECIFIC CRITERIA/ADDITIONAL DOCUMENTATION FORM FOUND BELOW

Prescribing provider's signature (signature and date stamps, or the signature of anyone other than the provider, are not acceptable)

I certify that all information provided is accurate and appropriately documented in the patient's medical chart.

Signature required: _____ **Date:** _____

Printed Name of Prescribing Provider:_____

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PRIOR AUTHORIZATION DESCRIPTION

Familial Hypercholesterolemia: REPATHA™ (evolocumab) and PRALUENT® (alirocumab)

Appendix A: Statin Contraindications

- Decompensated liver disease (symptoms can include jaundice, pruritus, ascites, variceal hemorrhage, or hepatic encephalopathy).
- Immune-mediated hypersensitivity to the HMG-CoA reductase inhibitor drug class (statins) as evidenced by an allergic reaction occurring with at least TWO different statins
- Laboratory-confirmed acute liver injury resulting from statin treatment
- Laboratory-confirmed rhabdomyolysis resulting from statin treatment
- Women who are breastfeeding, pregnant or are actively trying to become pregnant

Appendix B: Zetia Contraindications/Reasons to Discontinue

- Moderate or severe hepatic impairment (CP classes B and C)
- Women who are breastfeeding/pregnant or are actively trying to become pregnant
- Immune-mediated hypersensitivity to the cholesterol absorption as evidenced by an allergic reaction including anaphylaxis, angioedema, rash, or urticaria

Appendix C: A moderate-intensity statin may be more appropriate for the following adult populations if not able to tolerate a high-intensity statin

- Multiple or serious comorbidities, including impaired renal or hepatic function
- Unexplained ALT elevations >3 times ULN
- Active liver disease
- History of previous statin intolerance or statin-related muscle disorder
- Patient characteristics or concomitant use of drugs affecting statin metabolism
- ≥75 years of age
- History of hemorrhagic stroke
- Asian ancestry

Clinical atherosclerotic cardiovascular disease (ASCVD) includes:

- Acute coronary syndromes, or history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack, or peripheral arterial disease presumed to be of atherosclerotic origin.

PRIOR AUTHORIZATION DESCRIPTION

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TABLE 1: Dosage Levels for Statin Therapy Intensity Levels		
Low-Intensity Statin Therapy	Moderate-Intensity Statin Therapy	High-Intensity Statin Therapy
Daily dose lowers LDL-C by < 30%, on average	Daily dose lowers LDL-C by 30% to 50%, on average	Daily dose lowers LDL-C by ≥ 50%, on average
• Simvastatin 10 mg • Pravastatin 10-20 mg • Lovastatin 20 mg • Fluvastatin 20-40 mg • Pitavastatin (Livalo) 1 mg	• Atorvastatin 10-20 mg • Rosuvastatin 5-10 mg • Simvastatin 20-40 mg • Pravastatin 40-80 mg • Lovastatin 40 mg • Fluvastatin XL (Lescol XL) 80 mg • Fluvastatin 40 mg twice daily • Pitavastatin (Livalo) 2-4 mg	• Atorvastatin 40-80 mg • Rosuvastatin 20-40 mg

TABLE 2: Dutch Lipid Clinic Network criteria for Familial Hypercholesterolemia	
Criteria	**Points**
Family History	
First-degree relative with known premature* coronary and vascular disease, **OR** First-degree relative with known LDL-C level above the 95th percentile	1
First-degree relative with tendinous xanthomata and/or arcus cornealis, **OR** Children aged < 18 years with LDL-C level above the 95th percentile	2
Clinical History	
Patient with premature* coronary artery disease	2
Patient with premature* cerebral or peripheral vascular disease	1
Physical examination	
Tendinous xanthomata	6
Arcus cornealis prior to age 45 years	4
Cholesterol levels mg/dL (mmol/liter)	
LDL-C ≥330 mg/dL (≥8.5)	8
LDL-C 250 – 329 mg/dL (6.5 – 8.4)	5
LDL-C 190 – 249 mg/dL (5.0 – 6.4)	3
LDL-C 155 – 189 mg/dL (4.0 – 4.9)	1
DNA analysis	
Functional mutation in the *LDLR, apo B* or *PCSK9* gene	8
Diagnosis (diagnosis is based on total number of points obtained)	
Definite familial hypercholesterolemia	>8
Probable familial hypercholesterolemia	6 – 8
Possible familial hypercholesterolemia	3 – 5
Unlikely familial hypercholesterolemia	<3

*Premature – men < 55 years or women < 60 years Apo B= apoliprotein B

LDL-C= low density lipoprotein cholesterol; LDLR=low density lipoprotein receptor FH=familial hypercholesterolemia

PCSK9=Proprotein convertase subtilisin/kexin type

CRITERIA/ADDITIONAL DOCUMENTATION
Heterozygous Familial Hypercholesterolemia (HeFH)

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BENEFICIARY INFORMATION	
Beneficiary ID:____ ____ ____ - ____ ____ ____ - ____ ____ ____	**DOB:**____ ____/____ ____/____ ____ ____ ____
Beneficiary Full Name:	

Heterozygous Familial Hypercholesterolemia (HeFH) Criteria

REPATHA™ (EVOLOCUMAB) and PRALUENT® (ALIROCUMAB)

Initial Approval Criteria for Repatha™ (evolocumab) or Praluent® (alirocumab) may be approved when the following criteria are met:

☐ Yes ☐ No	The member is ≥ 18 years of age.
AND	
☐ Yes ☐ No	Repatha™ (evolocumab) or Praluent® (alirocumab) must be prescribed by or in consultation with a cardiologist, endocrinologist or lipid specialist and there is clinical documentation of one of the following: a.) Presence of a mutation in the LDLR, ApoB, PCSK9 or ARH adaptor protein (LDLRAP1) gene; **OR** b.) Physical signs of FH, such as presence of tendon xanthomas, corneal arcus in a member < 45 years of age, tuberous xanthomas, or xanthelasma; **OR** c.) Clinical diagnosis based on the World Health Organization (WHO)/Dutch Lipid Clinical Network criteria with a "probable familial hypercholesterolemia" score of ≥ 6 points (see Table 2)
AND	
☐ Yes ☐ No	Unable to meet LDL-C goal after treatment of at least 2 sequential 12-week trials of different high intensity statins [(i.e., atorvastatin ≥40mg or rosuvastatin ≥20mg] with at least one concomitant 12-week use of Zetia (ezetimibe) 10mg UNLESS contraindicated or not tolerated. Adherence to the current statin regimen must be evidenced by consistent pharmacy claims over the past 12 weeks, unless new to Medicaid.
AND	
☐ Yes ☐ No	Use of the PCSK9 inhibitor will be concomitant with a maximally-tolerated statin, and ezetimibe (Zetia) unless contraindicated/intolerant. (See Appendices A and C)

Recommended Dosing Regimen and Authorization Limit

Drug	Dosing Regimen
Praluent®	150 mg SC Q 2 weeks
Repatha™	140mg SC Q 2 weeks

Reauthorization Criteria:

☐ Yes ☐ No	Criteria outlined for initial Prior Authorization has been satisfied;
AND	
☐ Yes ☐ No	Is there clinical evidence of ongoing concomitant lipid lowering therapy (statin, ezetimibe, unless contraindicated / not tolerated);
AND	
☐ Yes ☐ No	Documentation of a LDL-C reduction from pretreatment level by ≥ 50% after adding Repatha (evolocumab) or by ≥ 40% after adding Praluent (alirocumab) for at least 90 days of therapy.

Authorization

Initial: If approved, initial coverage will be granted for up to 12 weeks.

Maintenance: If approved, maintenance coverage will be reauthorized for periods of up to 52 weeks.

APPENDICES AND TABLES CAN BE FOUND IN THE INSTRUCTION SHEET

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