

State of Oklahoma **Oklahoma Health Care Authority** PCSK9 Inhibitor Prior Authorization Form

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Pharmacy Section					
Ме	Member Name:	Date of Birth:	Member ID#:		
Ph	Pharmacy NPI: Pharm	acy Phone:	Pharmacy Fay:		
Pharmacy Name:		Pharmacist Na	me:		
Pro	Prescriber NPI: Prescri	ber Name:	Specialty:		
Pr NE	Prescriber Phone: Prescrib	oer ⊢ax:	Drug Name/Strengtn: Fill Quantity:	Day Supply:	
Pharmacy Name: Pharmacist Name: Pharmacy Name: Pharmacy Name: Specialty: Prescriber Name: Specialty: Prescriber Phone: Prescriber Fax: Drug Name/Strength: NDC: Regimen: Fill Quantity: Day Supply: Has member been trained on proper administration and storage of this medication? Yes No Pharmacist Signature: No				ау Зирріу	
Ph	Pharmacist Signature:	ation and storage or th	Date:		
	Prescriber Section				
All information must be provided and SoonerCare may verify through further requested documentation. The					
member's prescription claim history will be reviewed prior to approval.					
For Initial Authorization (Initial approval will be for the duration of 3 months):					
 Please indicate member's diagnosis: Homozygous familial hypercholesterolemia (HoFH) confirmed by 1 of the following: 					
	Untreated total cholesterol >500mg/dL and at least 1 of the following:				
 Documented evidence of definite HeFH in both parents; or Presence of tendinous/cutaneous xanthoma prior to age 10 years 					
Documented functional mutation(s) in both LDL receptor alleles via genetic testing** (**Please note if this option is selected, genetic testing results must be submitted with the prior authorization request				rization request)	
	☐ Primary hyperlipidemia	enelic lesting results must	be submitted with the phor author	ization request)	
) (to reduce the rick of m	wocardial infarction, stroke, co	vronary.	
	■ Established cardiovascular disease (CVD) (to reduce the risk of myocardial infarction, stroke, coronary revascularization, and unstable angina requiring hospitalization). Please provide supporting diagnoses/conditions				
	and dates of occurrence signifying established CVD:				
			f occurrence:		
	Diagnosis/condition:	Date o	f occurrence:		
2.	Please specify the member's current statin the	erapy:			
	a) Drug Name: Do	ose: Durat	ion of treatment:		
	b) Has member been adherent to high-dose	statin therapy for at least	st 12 continuous weeks? Yes_	No	
		c) If "Yes", please provide member's LDL-C level following 12 weeks of statin therapy: SoonerCare claims analysis will be conducted to verify adherence.			
		d) If member is statin intolerant due to myalgia, provide creatine kinase (CK) labs verifying rhabdomyolysis.			
		Members with myalgia not confirmed by CK labs must have at least 2 trials of lower dose statin therapy or failure of			
intermittent dosina.				apy or randre or	
3.	3. Member's baseline LDL-C: Curr	ent LDL-C:	Goal LDL-C:		
	4. How will this medication be used? ☐ Monoth				
	5. Has the member been counseled on proper administration and storage of PCSK9 therapy? Yes No				
	· · · · · · · · · · · · · · · · · · ·				
	For Continued Authorization:				
1.	 Has member been compliant with PCSK9 Inh Has PCSK9 Inhibitor treatment been effective 		_No		
	 Please provide a recent LDL-C level for this n 				
Ο.	o. Thease provide a recent EBE-O lever for this h	iciliboi	Date taken	_	
Pr	Prescriber Signature:	Dat	e:		
	By signature, the physician confirms the criteria information above is accurate and verifiable in patient records. Please do not send in chart				
not	notes. Specific information will be requested if necessa	ry. Failure to complete this	form in full will result in processing	g delays.	
	Member (Patient)	Section For Initial	Authorization Only		
	<u> </u>				
	Please have the member initial after each line, fill		the bottom.		
1.	1. I understand this medicine must be injected. Initials:				
	2. I understand I must give myself a shot everyweek(s). Initials:				
	B. I understand this medication must be kept in the refrigerator. Initials: I. I will not leave this medication in the car or anywhere it would get hot. Initials:				
	5. I understand this medication will not be replaced if I leave it out of the refrigerator. Initials:				
	Member Signature: Date:				

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

> University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014

Phone: 1-800-522-0114 Option 4

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