SoonerCare
Oklahoma Health Care Authority

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

Pharmacy Section

Member Name:_____ ***Date of Birth:***_____ ***Member ID#:***_____
Pharmacy NPI:_____ ***Pharmacy Phone:***_____ ***Pharmacy Fax:***_____
Pharmacy Name:_____ ***Pharmacist Name:***_____
Prescriber NPI:_____ ***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: _____ **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):

1. 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)*
   - ☐ Primary hyperlipidemia
   - ☐ 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:

   Diagnosis/condition: _____ Date of occurrence:_____
   Diagnosis/condition: _____ Date of occurrence:_____
2. Please specify the member's current statin therapy:
   a) Drug Name:_____ Dose:_____ Duration of treatment:_____
   b) Has member been adherent to high-dose statin therapy for at least 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 dosing.
3. Member's baseline LDL-C:_____ Current LDL-C:_____ Goal LDL-C:_____
4. How will this medication be used? ☐ Monotherapy ☐ Adjunct to statin therapy, diet, and exercise
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 Inhibitor treatment? Yes☐ No☐
2. Has PCSK9 Inhibitor treatment been effective for this member? Yes☐ No☐
3. Please provide a recent LDL-C level for this member:_____ Date taken:_____

Prescriber Signature: _____ **Date:** _____
By signature, the physician confirms the criteria information above is accurate and verifiable in patient records. Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

Member (Patient) Section For Initial Authorization Only

Please have the member initial after each line, fill in all blanks, and sign at the bottom.

1. I understand this medicine must be injected. **Initials: _____**
2. I understand I must give myself a shot every _____ week(s). **Initials: _____**
3. I understand this medication must be kept in the refrigerator. **Initials: _____**
4. 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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