OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Repatha® (evolocumab) Prior Authorization Form

Member Name:_____ Date of Birth:_____ Member ID#:_____

Drug Information

Pharmacy Billing (NDC:_____) Start Date (or date of next dose):_____

Dose:_____ Regimen:_____

Pharmacy Information

Pharmacy NPI:_____ Pharmacy Name:_____

Pharmacy Phone:_____ Pharmacy Fax:_____

Prescriber Information

Prescriber NPI:_____ Prescriber Name:_____

Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____

Criteria

For Initial Authorization *(Initial approval will be for the duration of 6 months):*

1. Please indicate member's diagnosis:

- ☐ **Heterozygous familial hypercholesterolemia (HeFH) confirmed by:** *(check all that apply)*
  - ☐ Documented functional mutation(s) in low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality via genetic testing ***(results of genetic testing must be submitted)***
  - ☐ Pre-treatment total cholesterol >290mg/dL or LDL-cholesterol (LDL-C) >190mg/dL
  - ☐ History of tendon xanthomas in either the member, first degree relative, or second degree relative
  - ☐ Dutch Lipid Clinic Network Criteria score of >8
- ☐ **Homozygous familial hypercholesterolemia (HoFH) defined by the presence of at least 1 of the following:**
  - ☐ Documented functional mutation(s) in both LDL receptor alleles or alleles known to affect LDL receptor functionality via genetic testing ***(results of genetic testing must be submitted)***
  - ☐ Untreated LDL-C >500mg/dL and at least 1 of the following:
    - ☐ Documented evidence of definite HeFH in both parents
    - ☐ Presence of tendinous/cutaneous xanthoma prior to 10 years of age
- ☐ **To reduce the risk of major adverse cardiovascular (CV) events (CV death, myocardial infarction, stroke, unstable angina requiring hospitalization, or coronary revascularization) in adults at increased risk for these events. Please provide supporting diagnoses/conditions/risk factors signifying increased risk of major adverse CV events:** _____

  _____

  _____
- ☐ **Primary hyperlipidemia**
  Untreated LDL-C level: _____(mg/dL); Current LDL-C level: _____(mg/dL)
- ☐ **Other:** _____

2. How will this medication be used? ☐ Monotherapy ☐ Adjunct to statin therapy, diet, and exercise

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

CONFIDENTIALITY NOTICE

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DRAFT

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Member Name:_____ Date of Birth:_____ Member ID#:_____

Criteria

For Initial Authorization, Continued:

3. Please specify the member's current statin therapy:
   a. Medication/strength:_____ Dosing regimen:_____ 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.
4. If the member has **not** been adherent to high-dose statin therapy for at least 12 continuous weeks, is the member intolerant to statin therapy? Yes☐ No☐
   a. If yes, please indicate 1 of the following:
   ☐ Rhabdomyolysis - creatine kinase (CK) labs verifying this diagnosis must be provided.
   ☐ An FDA labeled contraindication to all statins. Provide contraindication:_____
   ☐ Documented intolerance to at least 2 different statins at lower doses or at intermittent dosing:
   Please provide all of the following:
      1) Medication/strength:_____ Dosing regimen:_____
      Duration of treatment:_____ Reason for discontinuation:_____
      2) Medication/strength:_____ Dosing regimen:_____
      Duration of treatment:_____ Reason for discontinuation:_____
5. Member's baseline LDL-C:_____ Current LDL-C:_____ Goal LDL-C:_____
6. Will the member be counseled on appropriate use, storage of the medication, and administration technique? Yes☐ No☐

For Continued Authorization:

1. Has member been compliant with evolocumab? Yes☐ No☐
2. Has evolocumab treatment been effective for this member? Yes☐ No☐
3. Please provide a recent LDL-C level for this member:_____ Date taken:_____

Additional Information: _____

_____

_____

Prescriber Signature: _____ Date:_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.
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.

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