

## PCSK9i Prior Authorization (PA) Request Form CT Medical Assistance Program

[To be used for authorization of Repatha, Praluent and Leqvio]

**To Be Completed By Prescriber**

<u>Prescriber Information</u>	<u>Patient Information</u>
Prescriber's NPI:	Patient's Medicaid ID Number:
Prescriber Name:	Patient Name:
Phone # ( )	Patient DOB:
Fax # ( )	Primary ICD diagnosis code:
<u>Prescription Information</u>	
Drug Requested:	Frequency of Dosing:
<input type="checkbox"/> New therapy <input type="checkbox"/> Continuation	Quantity Requested:

### Clinical Information

<b><u>Repatha: Patients aged 10 - 17 years:</u></b> Is there a diagnosis of homozygous familial hypercholesterolemia (HoFH) or heterozygous familial hypercholesterolemia (HeFH) and requires additional lowering of low-density lipoprotein cholesterol (LDL-C) as an adjunct to diet and other LDL-C lowering therapies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b><u>Repatha : Patients 18 years of age or older:</u></b> Is there a diagnosis of primary hyperlipidemia including, homozygous familial hypercholesterolemia (HoFH), heterozygous familial hypercholesterolemia (HeFH) or clinical atherosclerotic cardiovascular disease (ASCVD) and requires additional lowering of low-density lipoprotein cholesterol (LDL-C) as an adjunct to diet and other LDL-C lowering therapies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b><u>Praluent: Patients aged 8 - 17 years:</u></b> Is there a diagnosis of heterozygous familial hypercholesterolemia (HeFH) and requires additional lowering of low-density lipoprotein cholesterol (LDL-C) as an adjunct to diet and other LDL-C lowering therapies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b><u>Praluent: Patients 18 years of age or older:</u></b> Is there a diagnosis of primary hyperlipidemia including, homozygous familial hypercholesterolemia (HoFH), heterozygous familial hypercholesterolemia (HeFH) or clinical atherosclerotic cardiovascular disease (ASCVD) and requires additional lowering of low-density lipoprotein cholesterol (LDL-C) as an adjunct to diet and other LDL-C lowering therapies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b><u>Leqvio: Patients 18 years of age or older:</u></b> Is there a diagnosis of primary hyperlipidemia including, heterozygous familial hypercholesterolemia (HeFH) or clinical atherosclerotic cardiovascular disease (ASCVD) and requires additional lowering of low-density lipoprotein cholesterol (LDL-C) as an adjunct to diet and maximally tolerated statin therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**If you answered 'NO' to all of the questions above, a Letter of Medical Necessity (LMN) must be reviewed for consideration. Please provide all relevant information relating to the medical necessity (see Conn. Gen. Stat § 17b-259b(a)) of either Repatha, Praluent or Leqvio for this patient. Submit request, via email, to [rx.lmn@ct.gov](mailto:rx.lmn@ct.gov).**

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.

I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1- to 17-83k-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the above-referenced member is a patient under my clinic's/practice's ongoing care. I understand that a prior authorization may not exceed one (1) year from the date of fill for non-controlled medications. Authorizations for Early Refill Requests are valid one time only.

**Prescriber Signature\*:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\* Mandatory (others may not sign for prescriber). **In accordance with federal law, prescribers must be enrolled in the Connecticut Medical Assistance Program (CMAP). CMAP will not pay for prescriptions written by a non-enrolled provider.**