TO: **Pharmacy Providers, Physicians, Nurse Practitioners, Physician Assistants, Clinics, Long Term Care Providers, and Hospitals**
RE: **New Prior Authorization Request Form for PCSK9 Inhibitors**

Effective February 1, 2016, Prior Authorization (PA) will be required for prescription benefit coverage of Proprotein Convertase Subtilisin Kexin type 9 (PCSK9) inhibitors for HUSKY A, HUSKY B, HUSKY C, and HUSKY D clients.

The U.S. Food and Drug Administration (FDA) has approved Praluent (alirocumab) and Repatha (evolocumab) as the first two cholesterol-lowering treatments in a new class of drugs known as PCSK9 inhibitors.

PCSK9 inhibitors are approved for use in addition to diet and maximally-tolerated statin therapy in adult patients with Heterozygous Familial Hypercholesterolemia (HeFH), or Homozygous Familial Hypercholesterolemia (HoFH), or clinical Atherosclerotic Cardiovascular Disease (ASCVD), such as heart attacks or strokes, who require additional lowering of LDL cholesterol.

Effective February 1, 2016, the PCSK9 Inhibitor PA Request Form must be used to request PA for PCSK9 inhibitors.

The new PA form is attached below and will be available on the www.ctdssmap.com Web page. From the Home page, go to Information → Publications → Authorization/Certification Forms → PCSK9 Inhibitor PA Form; or from the Home page go to Pharmacy Information → Pharmacy Program Publications → PCSK9 Inhibitor PA Form.

STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
PO BOX 2943 HARTFORD, CT 06104
TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110 OR (860) 269-2035
(This and other PA forms are posted on www.ctdssmap.com and can be accessed by clicking on the pharmacy icon)

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

[To be used for authorization of Repatha and Praluent]

To Be Completed By Prescriber

Prescriber Information	**Patient Information**
Prescriber's NPI:	Patient's Medicaid ID Number:
Prescriber Name:	Patient Name:
Phone # ( )	Patient DOB: / /
Fax # ( )	Primary ICD diagnosis code:
Prescription Information	
Drug Requested:	Frequency of Dosing:
□ New therapy □ Continuation	Quantity Requested:

Clinical Information

Is the patient 18 years of age or older?	□ Yes	□ No
Is there a diagnosis of atherosclerotic cardiovascular disease (ASCVD), heterozygous familial hypercholesterolemia (HeFH), or homozygous familial hypercholesterolemia (HoFH)?	□ Yes	□ No
Has there been prior treatment with the highest available dose or maximally-tolerated dose of high intensity statin (atorvastatin or rosuvastatin) AND ezetimibe for at least three continuous months with failure to reach target LDL-C (70 mg/dl for patients with clinical ASCVD and 100 mg/dl for patients with HeFH or HoFH and no history of clinical ASCVD)?	□ Yes	□ No

If you answered "No" to any of the questions above, please provide any other information relating to the medical necessity (see Conn. Gen. Stat. § 17b-259b(a)) of this drug for this patient.

_____
_____
_____
_____

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 six (6) months from the date of fill for controlled medications and 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.**