

STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

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

<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

Repatha ONLY: Patients aged 13 – 17 years: Is there a diagnosis of homozygous familial hypercholesterolemia (HoFH)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Repatha and Praluent: Patients 18 years of age or older: Is there a diagnosis of atherosclerotic cardiovascular disease (ASCVD), heterozygous familial hypercholesterolemia (HeFH), or homozygous familial hypercholesterolemia (HoFH)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Repatha and Praluent: Patients 18 years of age or older: 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered “No” to all 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 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). <u>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.</u>

This form (and attachments) contains protected health information (PHI) for DXC Technology and is covered by the Electronic Communications Privacy Act, 18 U.S.C. § 2510-2521 and the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, which is intended only for the use of prior authorization. Any unintended recipient is hereby notified that the information is privileged and confidential, and any use, disclosure, or reproduction of this information is prohibited. Any unintended recipient should contact DXC Technology by telephone at (860) 255-3900 or by e-mail immediately and destroy the original message.