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

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

Repatha ONLY: Patients aged 13 – 17 years: Is there a diagnosis of homozygous familial hypercholesterolemia (HoFH)?	□ Yes □ 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)?	□ Yes □ 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)?	□ Yes □ 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). **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.**