US Family Health Plan
Prior Authorization Request Form for
alirocumab **(Praluent)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization will expire in one year. For renewal of therapy an initial prior authorization approval is required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the request for renewal of therapy? *Please choose "No" if the patient did not previously have a TRICARE/USFHP approved PA for Praluent*	☐ Yes Skip to question 21 on page 2	☐ No Proceed to question 2
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question 3	☐ No **STOP** Coverage not approved
3. Is the requested medication being prescribed by a cardiologist, lipidologist, or endocrinologist?	☐ Yes Proceed to question 4	☐ No **STOP** Coverage not approved
4. Does the patient have a diagnosis of either heterozygous familial hypercholesterolemia (HeFH) or clinical atherosclerotic cardiovascular disease (ASCVD)?	☐ Yes Proceed to question 5	☐ No **STOP** Coverage not approved
5. Has the patient tried Repatha (evolocumab)?	☐ Yes Proceed to question 6	☐ No **STOP** Coverage not approved
6. Will the patient be on concurrent statin therapy at a maximal tolerated dose while on the requested medication?	☐ Yes **SKIP** to question **16** *on next page*	☐ No Proceed to question 7
7. Has the patient experienced intolerable and persistent (for longer than 2 weeks) muscle symptoms (muscle pain, weakness, cramps) while on statin therapy?	☐ Yes Proceed to question 8	☐ No **SKIP** to question **10** *on next page*
8. Has the patient undergone at least 2 trials of statin rechallenges with reappearance of muscle symptoms? -- NOTE: that is, the patient has had 2 trials of statins with muscle symptoms	☐ Yes **SKIP** to question **11** *on next page*	☐ No Proceed to question 9
9. Has the patient had a creatine kinase (CK) level greater than 10 times the upper limit of normal OR rhabdomyolysis with CK greater than 10,000 international units per liter (IU/L) that is unrelated to statin use?	☐ Yes **SKIP** to question **11** *on next page*	☐ No Proceed to question 10 *on next page*

Continue to next page

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10. Does the patient have a contraindication to the use of a statin? -- NOTE: Please select the option that best applies to this patient's condition.	☐ Active Liver Disease (including unexplained persistent elevations in hepatic transaminase levels) - **Proceed** to question 11 ☐ Hypersensitivity - **Proceed** to question 11 ☐ Pregnancy - **Proceed** to question 11 ☐ Nursing mothers - **Proceed** to question 11 ☐ None of the above **– STOP – Coverage not approved**		
11. What is the indication or diagnosis?	☐ Heterozygous familial hypercholesterolemia (HeFH) - **SKIP** to question **20** ☐ Clinical atherosclerotic cardiovascular disease (ASCVD) - Proceed to question 12		
12. Has the patient tried both atorvastatin (Lipitor) at a dose of 40 mg to 80 mg AND rosuvastatin (Crestor) at a dose of 20 mg to 40 mg for at least 4 to 6 weeks each?		☐ Yes **SKIP** to question **15**	☐ No Proceed to question 13
13. Has the patient tried any statin at a maximally tolerated dose in combination with ezetimibe (Zetia) for at least 4 to 6 weeks?		☐ Yes **SKIP** to question **15**	☐ No Proceed to question 14
14. Has the patient tried ezetimibe (Zetia) either as monotherapy (alone) or with other lipid-lowering therapy for at least 4 to 6 week? -- NOTE: Other lipid-lowering therapy such as fenofibrate, niacin, or a bile acid sequestrant.		☐ Yes Proceed to question 15	☐ No **STOP** Coverage not approved
15. Does the patient have an LDL level greater than 100 mg/dL despite lipid-lowering therapy at maximal tolerated doses?		☐ Yes **SKIP** to question **20**	☐ No **STOP** Coverage not approved
16. What is the indication or diagnosis?	☐ Heterozygous familial hypercholesterolemia (HeFH) - **SKIP** to question **20** ☐ Clinical atherosclerotic cardiovascular disease (ASCVD) - Proceed to question 17		
17. Has the patient tried both atorvastatin (Lipitor) at a dose of 40 mg to 80 mg AND rosuvastatin (Crestor) at a dose of 20 mg to 40 mg for at least 4 to 6 weeks each?		☐ Yes **SKIP** to question **19**	☐ No Proceed to question 18
18. Has the patient tried any statin at a maximally tolerated dose in combination with ezetimibe (Zetia) for at least 4 to 6 weeks?		☐ Yes Proceed to question 19	☐ No **STOP** Coverage not approved
19. Does the patient have an LDL level greater than 100 mg/dL despite lipid-lowering therapy at maximal tolerated doses?		☐ Yes Proceed to question 20	☐ No **STOP** Coverage not approved
20. Is the patient pregnant or breastfeeding?		☐ Yes **STOP** Coverage not approved	☐ No Proceed to question 24
21. Does the patient have a documented positive response to therapy with an LDL less than 70 mg/dL (or an LDL decrease greater than 30% from baseline)?		☐ Yes Proceed to question 22	☐ No **STOP** Coverage not approved
22. Does the patient have documented adherence to therapy?		☐ Yes Proceed to question 23	☐ No **STOP** Coverage not approved
23. Is this renewal request being submitted by a cardiologist, lipidologist, or endocrinologist OR by a primary care provider in consultation with the initial prescribing cardiologist, endocrinologist, or lipidologist?		☐ Yes Proceed to question 24	☐ No **STOP** Coverage not approved
24. What dose is being prescribed?		☐ 75 mg every 2 weeks – Sign and date on page 3 ☐ 150 mg every 2 weeks – Sign and date on page 3 ☐ Other - **Coverage not approved**	

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Step 3	**I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[10 May 2019]