# US Family Health Plan
# Prior Authorization Request Form for evolocumab **(Repatha)**

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 855-273-5735

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 Tricare prior authorization approval is required.

## Step 1

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

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

## Step 2

**Please complete the clinical assessment:**

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| **1. Is the request for renewal of therapy?** *Please choose "No" if the patient did not previously have a TRICARE approved PA for Repatha* | ☐ Yes<br>Proceed to question 8 | ☐ No<br>Proceed to question 2 |
| **2. What is the indication or diagnosis?** | ☐ Homozygous familial hypercholesterolemia (HoFH) – Proceed to question 3<br>☐ Heterozygous familial hypercholesterolemia (HeFH) – **SKIP** to question **14**<br>☐ Clinical atherosclerotic cardiovascular disease (ASCVD) – **SKIP** to question **14**<br>☐ Other – **STOP** - **Coverage not approved** | |
| **3. Is the patient 13 years of age or older?** | ☐ Yes<br>Proceed to question 4 | ☐ No<br>**STOP**<br>Coverage not approved |
| **4. Is the requested medication being prescribed by a cardiologist, lipidologist, or endocrinologist?** | ☐ Yes<br>Proceed to question 5 | ☐ No<br>**STOP**<br>Coverage not approved |
| **5. Is the patient receiving other LDL-lowering therapies (for example, a statin, ezetimibe [Zetia], LDL apheresis)?** | ☐ Yes<br>Proceed to question 6 | ☐ No<br>**STOP**<br>Coverage not approved |
| **6. Does the patient require additional lowering of LDL cholesterol?** | ☐ Yes<br>Proceed to question 7 | ☐ No<br>**STOP**<br>Coverage not approved |
| **7. Is the patient pregnant or breastfeeding?** | ☐ Yes<br>**STOP**<br>Coverage not approved | ☐ No<br>Proceed to question 12 |
| **8. Does the patient a documented positive response to therapy with an LDL less than 70 mg/dL (or an LDL decrease greater than 30% from baseline)?** | ☐ Yes<br>Proceed to question 9 | ☐ No<br>**STOP**<br>Coverage not approved |
| **9. Does the patient have documented adherence to therapy?** | ☐ Yes<br>Proceed to question 10 | ☐ No<br>**STOP**<br>Coverage not approved |

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| **10. 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<br>Proceed to question 11 | ☐ No<br>**STOP**<br>Coverage not approved |
| **11. What is the indication or diagnosis?** | ☐ Homozygous familial hypercholesterolemia (HoFH) – Proceed to question **12**<br>☐ Heterozygous familial hypercholesterolemia (HeFH) – **SKIP** to question **13**<br>☐ Clinical atherosclerotic cardiovascular disease (ASCVD) – **SKIP** to question **13**<br>☐ Other – **STOP** - **Coverage not approved** | |
| **12. What dose is being prescribed?** | ☐ 420 mg every 4 weeks – Sign and date on page 3<br>☐ Other – **STOP** - **Coverage not approved** | |
| **13. What dose is being prescribed?** | ☐ 140 mg every 2 weeks – Sign and date on page 3<br>☐ 420 mg every 4 weeks as one Pushtronex injection – Sign and date on page 3<br>☐ 420 mg every 4 weeks as three 140 mg syringes/autoinjectors – **STOP - Coverage not approved**<br>☐ Other – **STOP - Coverage not approved** | |
| **14. Is the requested medication being prescribed by a cardiologist, lipidologist, or endocrinologist?** | ☐ Yes<br>Proceed to question 15 | ☐ No<br>**STOP**<br>Coverage not approved |
| **15. Is the patient 18 years of age or older?** | ☐ Yes<br>Proceed to question 16 | ☐ No<br>**STOP**<br>Coverage not approved |
| **16. Will the patient be on concurrent statin therapy at a maximal tolerated dose while on the requested medication?** | ☐ Yes<br>**SKIP** to question 26 | ☐ No<br>Proceed to question 17 |
| **17. Has the patient experienced intolerable and persistent (for longer than 2 weeks) muscle symptoms (muscle pain, weakness, cramps) while on statin therapy?** | ☐ Yes<br>Proceed to question 18 | ☐ No<br>**Skip** to question 20 |
| **18. 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<br>**SKIP** to question **21** | ☐ No<br>Proceed to question 19 |
| **19. 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<br>**SKIP** to question **21** | ☐ No<br>Proceed to question 20 |
| **20. 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 21<br>☐ Hypersensitivity - **Proceed** to question 21<br>☐ Pregnancy - **Proceed** to question 21<br>☐ Nursing mothers - **Proceed** to question 21<br>☐ None of the above – **STOP – Coverage not approved** | |
| **21. What is the indication or diagnosis?** | ☐ Heterozygous familial hypercholesterolemia (HeFH) - **SKIP** to question **30**<br>☐ Clinical atherosclerotic cardiovascular disease (ASCVD) - Proceed to question 22 | |
| **22. 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<br>**SKIP** to question **25** | ☐ No<br>Proceed to question 23 |

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| **23. Has the patient tried any statin at a maximally tolerated dose in combination with ezetimibe (Zetia) for at least 4 to 6 weeks?** | ☐ Yes<br>**SKIP** to question **25** | ☐ No<br>Proceed to question 24 |
| **24. Has the patient tried ezetimibe (Zetia) either as monotherapy (alone) or with other lipid-lowering therapy for at least 4 to 6 weeks? -- NOTE: Other lipid-lowering therapy such as fenofibrate, niacin, or a bile acid sequestrant.** | ☐ Yes<br>Proceed to question 25 | ☐ No<br>**STOP**<br>Coverage not approved |
| **25. Does the patient have an LDL level greater than 100 mg/dL despite lipid-lowering therapy at maximal tolerated doses?** | ☐ Yes<br>**SKIP** to question **30** | ☐ No<br>**STOP**<br>Coverage not approved |
| **26. What is the indication or diagnosis?** | ☐ Heterozygous familial hypercholesterolemia (HeFH) - **SKIP** to question **30**<br>☐ Clinical atherosclerotic cardiovascular disease (ASCVD) - Proceed to question 27 | |
| **27. 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<br>SKIP **to question** 29 | ☐ No<br>Proceed to question 28 |
| **28. Has the patient tried any statin at a maximally tolerated dose in combination with ezetimibe (Zetia) for at least 4 to 6 weeks?** | ☐ Yes<br>**Proceed to question 29** | ☐ No<br>**STOP**<br>Coverage not approved |
| **29. Does the patient have an LDL level greater than 100 mg/dL despite lipid-lowering therapy at maximal tolerated doses?** | ☐ Yes<br>**Proceed to question 30** | ☐ No<br>**STOP**<br>Coverage not approved |
| **30. Is the patient pregnant or breastfeeding?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>**Proceed to question 31** |
| **31. What dose is being prescribed?** | ☐ 140 mg every 2 weeks – Sign and date below<br>☐ 420 mg every 4 weeks as one Pushtronex injection – Sign and date below<br>☐ 420 mg every 4 weeks as three 140 mg syringes/autoinjectors – **Coverage not approved**<br>☐ **Other -** Coverage not approved | |

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

Prescriber Signature _____ Date _____