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**

Clinical documentation may be required.
Prior authorization does not expire.

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. What is the diagnosis or indication?	☐ Homozygous familial hypercholesterolemia (HoFH) - Proceed to question **2** ☐ Heterozygous familial hypercholesterolemia (HeFH) - Proceed to question **3** ☐ Clinical atherosclerotic cardiovascular disease (ASCVD) - Proceed to question **4** ☐ Other **– STOP – Coverage not approved**	
2. Is the patient greater than or equal to 10 years of age?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
3. Is the patient greater than or equal to 10 years of age?	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved
4. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved
5. Is the patient receiving other LDL-lowering therapies (for example, statin, ezetimibe, LDL apheresis), and requires additional lowering of LDL cholesterol?	☐ Yes Proceed to question **7**	☐ 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 Proceed to question **13**	☐ No Proceed to question **9**
7. Is the patient pregnant or breastfeeding?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **8**

8. Is the prescribed dosage documented as 140 mg every 2 weeks, OR 420 mg every 4 weeks? Note: Only patients with homozygous familial hypercholesterolemia (HoFH) will be allowed to use 3 of the 140 mg syringes to make the 420 mg dose.	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved
9. 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 **10**	☐ No Proceed to question **12**
10. Has the patient undergone at least 2 trials of statin re-challenges with reappearance of muscle symptoms? -- NOTE: that is, the patient has had 2 trials of statins with muscle symptoms.	☐ Yes Proceed to question **13**	☐ No Proceed to question **11**
11. 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 Proceed to question **13**	☐ No Proceed to question **12**
12. 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 **13** ☐ Hypersensitivity - Proceed to question **13** ☐ Pregnancy - Proceed to question **13** ☐ Nursing mothers - Proceed to question **13** ☐ None of the above - **STOP – Coverage not approved**	
13. Is the patient pregnant or breastfeeding?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **14**
14. What is the indication or diagnosis?	☐ Clinical atherosclerotic cardiovascular disease (ASCVD) - Proceed to question **16** ☐ Heterozygous familial hypercholesterolemia (HeFH) - Proceed to question **15**	
15. Is the prescribed dosage documented as 140 mg every 2 weeks, OR 420 mg every 4 weeks?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved
16. Is the patient at very high risk for future ASCVD events? NOTE: patients at very high risk for future ASCVD events include those with a history of multiple major ASCVD events or 1 major ASCVD event and multiple high risk conditions. Refer to the 2022 ACC Expert Consensus Decision Pathway on the role of nonstatin therapies for LDL-cholesterol lowering in the management of ASCVD for more information.	☐ Yes Proceed to question **17**	☐ No Proceed to question **18**
17. Does the patient have an LDL level greater than 55 mg/dL despite statin at maximal tolerated doses, or prior to any PCSK9 use?	☐ Yes Proceed to question **19**	☐ No **STOP** Coverage not approved
18. Does the patient have an LDL level greater than 70 mg/dL despite statin at maximal tolerated doses, or prior to any PCSK9 use?	☐ Yes Proceed to question **19**	☐ No **STOP** Coverage not approved
19. Has the patient tried EITHER atorvastatin (Lipitor) at a dose of 40 mg to 80 mg OR rosuvastatin (Crestor) at a dose of 20 mg to 40 mg for at least 4 to 6 weeks each?	☐ Yes Proceed to quesion **22**	☐ No Proceed to question **20**
20. 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 **22**	☐ No Proceed to question **21**

21. Has the patient tried ezetimibe (Zetia) as monotherapy (alone) for at least 4 to 6 weeks?	☐ Yes Proceed to question **22**	☐ No **STOP** Coverage not approved
22. Is the prescribed dosage documented as 140 mg every 2 weeks, OR 420 mg every 4 weeks?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Step 3

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

Prescriber Signature _____ Date _____