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**

When prescribed by a cardiologist, endocrinologist or cardiac transplant specialist, prior authorization is not 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. **Is the requested medication being requested by a cardiologist, endocrinologist or cardiac transplant specialist?**		☐ Yes **Sign and date below**	☐ No Proceed to question **2**
2. **What is the diagnosis or indication?**	☐ Homozygous familial hypercholesterolemia (HoFH) - Proceed to question **3** ☐ Heterozygous familial hypercholesterolemia (HeFH) - Proceed to question **4** ☐ Clinical atherosclerotic cardiovascular disease (ASCVD) - Proceed to question **5** ☐ High risk for ASCVD – Proceed to question 5 ☐ Other **– STOP – Coverage not approved**		
3. **Is the patient 10 years of age or older?**		☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved
4. **Is the patient 10 years of age or older?**		☐ Yes Proceed to question **7**	☐ No **STOP** Coverage not approved
5. **Is the patient 18 years of age or older?**		☐ Yes Proceed to question **7**	☐ No **STOP** Coverage not approved

6. **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 **8**	☐ No **STOP** Coverage not approved
7. **Will the patient be on concurrent statin therapy at a maximal tolerated dose while on the requested medication?**	☐ Yes Proceed to question **14**	☐ No Proceed to question **10**
8. **Is the patient pregnant or breastfeeding?**	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **9**
9. **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
10. **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 **11**	☐ No Proceed to question **13**
11. **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 **14**	☐ No Proceed to question **12**
12. **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 **14**	☐ No Proceed to question **13**
13. **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 **14** ☐ Hypersensitivity - Proceed to question **14** ☐ Pregnancy - Proceed to question **14** ☐ Nursing mothers - Proceed to question **14** ☐ None of the above - **STOP – Coverage not approved**	
14. **Is the patient pregnant or breastfeeding?**	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **15**
15. **What is the indication or diagnosis?**	☐ Clinical atherosclerotic cardiovascular disease (ASCVD) - Proceed to question **17** ☐ Heterozygous familial hypercholesterolemia (HeFH) - Proceed to question **16** ☐ High risk for clinical atherosclerotic cardiovascular disease (ASCVD- **24** ☐ Other **– STOP – Coverage not approved**	

16. 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
17. 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 non-statin therapies for LDL-cholesterol lowering in the management of ASCVD for more information.	☐ Yes Proceed to question **18**	☐ No Proceed to question **19**
18. 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 **20**	☐ No **STOP** Coverage not approved
19. 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 **20**	☐ No **STOP** Coverage not approved
20. 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 question **23**	☐ No Proceed to question **21**
21. 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 **23**	☐ No Proceed to question **22**
22. Has the patient tried ezetimibe (Zetia) as monotherapy (alone) for at least 4 to 6 weeks?	☐ Yes Proceed to question **23**	☐ No **STOP** Coverage not approved
23. 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
24. Does the patient have LDL level greater than 190 mg/dL?	☐ Yes Proceed to question **28**	☐ No Proceed to question **25**
25. Does the patient have diabetes and LDL level less than 190 mg/dL?	☐ Yes Proceed to question **28**	☐ No Proceed to question **26**
26. Does the patient have LDL 70 to 189 mg/dL and an estimated 10-year risk for ASCVD greater than 7.5%?	☐ Yes Proceed to question **28**	☐ No Proceed to question **27**
27. Does the patient have LDL level less than 190 mg/dL and evidence of significant subclinical atherosclerosis defined as: Significant atherosclerotic plaque observed in an asymptomatic patient on any of the following diagnostic studies: coronary artery calcification noted on computed tomography (CT) studies, including calcium scoring, cardiac CT coronary angiography, chest CT for ruling out pulmonary embolism, chest CT for lung cancer screening, or diagnostic chest CT; carotid plaque noted on carotid ultrasound or angiography; or abnormal ankle-brachial index or plaque noted on peripheral arterial angiography?	☐ Yes Proceed to question **28**	☐ No **STOP** Coverage not approved

28. **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 question 31**	☐ No **Proceed to question 29**
29. **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 31**	☐ No **Proceed to question 30**
30. **Is the patient statin intolerant, and has tried ezetimibe (Zetia) as monotherapy (alone) for at least 4 to 6 weeks?**	☐ Yes **Proceed to question 31**	☐ No **STOP** **Coverage not approved**
31. **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 _____

[29 Jan 2025]