OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Kynamro® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Homozygous familial hypercholesterolemia (HoFH)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Select if medical records (e.g., chart notes, laboratory values) will be submitted documenting the patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) as confirmed by the following:*

- ❑ Genetic confirmation of 2 mutations in the LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1 (i.e., LDLRAP1 or ARH)
- ❑ Untreated LDL-C greater than 500mg/dL or treated LDL-C greater than 300 mg/dL
- ❑ Xanthoma before 10 years of age
- ❑ Evidence of heterozygous familial hypercholesterolemia (HeFH) in both parents

**Please note: Chart documentation of the above is required to be submitted along with this fax.*

Is the patient receiving other lipid-lowering therapy (e.g., statin, ezetimibe)? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication, or intolerance to Repatha therapy? ❑ **Yes** ❑ **No**

Will Kynamro be used as adjunct to a low-fat diet and exercise regimen? ❑ **Yes** ❑ **No**

Select the prescriber's specialty:

❑ Cardiologist ❑ Endocrinologist ❑ Lipid specialist

Will Kynamro be used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following questions:

Does the patient continue to receive other lipid-lowering therapy (e.g., statin, ezetimibe)? ❑ **Yes** ❑ **No**

Will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has had LDL-C reduction while on Kynamro therapy?* ❑ **Yes** ❑ **No**

**Please note: Chart documentation of the above is required to be submitted along with this fax.*

Is the patient continuing a low-fat diet and exercise regimen? ❑ **Yes** ❑ **No**

Select the prescriber's specialty:

❑ Cardiologist ❑ Endocrinologist ❑ Lipid specialist

Will Kynamro be used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor? ❑ **Yes** ❑ **No**

Kynamro® Prior Authorization Request Form (Page 2 of 2)

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Quantity Limit Requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed 1-800-527-0531