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

Repatha® Prior Authorization Request Form (Page 1 of 3)

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

Patient Information (required)

Patient 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)
❑ Primary hyperlipidemia
  ❑ Atherosclerotic cardiovascular disease (ASCVD)
  ❑ Heterozygous familial hypercholesterolemia (HeFH)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

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

Select if Repatha is prescribed by one of the following specialists:
❑ Cardiologist ❑ Endocrinologist ❑ Lipid specialist

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

Does the prescriber attest to the following: the information provided is true and accurate to the best of their knowledge and they understand that OptumRx may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided? ❑ **Yes** ❑ **No**

For primary hyperlipidemia (HeFH and/or ASCVD), also answer the following:

Select if the patient has heterozygous familial hypercholesterolemia (HeFH) as confirmed by the following:
❑ Untreated/pre-treatment LDL-cholesterol (LDL-C) > 190 mg/dL in an adult or > 155 mg/dL in a child less than 16 years of age
❑ Family history of myocardial infarction in first-degree relative less than 60 years of age
❑ Family history of myocardial infarction in second-degree relative less than 50 years of age
❑ Family history of LDL-C > 190 mg/dL in first- or second-degree relative
❑ Family history of familial hypercholesterolemia in first- or second-degree relative
❑ Family history of tendinous xanthomata and/or arcus cornealis in first- or second-degree relative

Select if there is submission of medical records (e.g., chart notes, laboratory values) documenting the following:*
❑ Functional mutation in the LDL receptor, ApoB, or PCSK9 gene
❑ Tendinous xanthomata
❑ Arcus cornealis before age 45

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

<continued on next page>

Repatha® Prior Authorization Request Form (Page 2 of 3)

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<continued from previous page>

Select if the patient has atherosclerotic cardiovascular disease (ASCVD) confirmed by the following:

- ❑ Acute coronary syndromes
- ❑ History of myocardial infarction
- ❑ Stable or unstable angina
- ❑ Peripheral arterial disease presumed to be of atherosclerotic origin
- ❑ Coronary or arterial revascularization
- ❑ Stroke
- ❑ Transient ischemic attack

Has the patient been receiving at least 12 consecutive weeks of **high-intensity** statin therapy [i.e., atorvastatin 40-80 mg, Crestor (rosuvastatin) 20-40 mg]? ❑ **Yes** ❑ **No**

Will the patient continue to receive a **high-intensity** statin at maximally tolerated dose? ❑ **Yes** ❑ **No**

Select if the patient is unable to tolerate **high-intensity** statin therapy as evidenced by one of the following intolerable and persistent (i.e., more than 2 weeks) symptoms:

- ❑ Myalgia (muscle symptoms without CK elevations)
- ❑ Myositis (muscle symptoms with CK elevations < 10 times upper limit of normal [ULN])

Has the patient been receiving at least 12 consecutive weeks of **moderate-intensity** statin therapy [i.e., atorvastatin 10-20 mg, Crestor (rosuvastatin) 5-10 mg, simvastatin 20-40 mg, pravastatin 40-80 mg, lovastatin 40 mg, Lescol XL (fluvastatin XL) 80 mg, fluvastatin 40 mg twice daily, or Livalo (pitavastatin) 2-4 mg]? ❑ **Yes** ❑ **No**

Will the patient continue to receive a **moderate-intensity** statin at maximally tolerated dose? ❑ **Yes** ❑ **No**

Has the patient been receiving at least 12 consecutive weeks of **low-intensity** statin therapy [i.e., simvastatin 10 mg, pravastatin 10-20mg, lovastatin 20mg, fluvastatin 20-40mg, Livalo (pitavastatin) 1 mg]? ❑ **Yes** ❑ **No**

Will the patient continue to receive a **low-intensity** statin at maximally tolerated dose? ❑ **Yes** ❑ **No**

Select if the patient is unable to tolerate **low-**, **moderate-**, and **high-intensity** statin therapy as evidenced by one of the following intolerable and persistent (i.e., more than 2 weeks) symptoms for low-, moderate-, and high-intensity statins:

- ❑ Myalgia (muscle symptoms without CK elevations)
- ❑ Myositis (muscle symptoms with CK elevations < 10 times upper limit of normal [ULN])

Does the patient have a labeled contraindication to all statins as documented in medical records? ❑ **Yes** ❑ **No**

Has the patient experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations > 10 times upper limit of normal? ❑ **Yes** ❑ **No**

Select if there is submission of medical records (e.g., laboratory values) documenting the following LDL-C values while on maximally tolerated lipid-lowering therapy ***within the last 120 days***:*

- ❑ LDL-C between 70 mg/dL and 99 mg/dL **with** ASCVD
- ❑ LDL-C ≥100 mg/dL **with** ASCVD
- ❑ LDL-C between 100 mg/dL and 129 mg/dL **without** ASCVD
- ❑ LDL-C ≥130 mg/dL **without** ASCVD

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

Has the patient been receiving at least 12 consecutive weeks of ezetimibe (Zetia) therapy as adjunct to maximally tolerated statin therapy? ❑ **Yes** ❑ **No**

If "no" to the above, does the patient have a history of **contraindication or intolerance** to ezetimibe? ❑ **Yes** ❑ **No**

For homozygous familial hypercholesterolemia (HoFH), also answer the following:

Select if there is submission of medical records (e.g., chart notes, laboratory values) documenting the patient has 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/pre-treatment LDL-cholesterol (LDL-C) > 500 mg/dL
- ❑ Treated LDL-C > 300 mg/dL
- ❑ Xanthoma before 10 years of age
- ❑ Evidence of heterozygous familial hypercholesterolemia 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, LDL, apheresis)? ❑ **Yes** ❑ **No**

Will Repatha be used in combination with Juxtapid (lomitapide)? ❑ **Yes** ❑ **No**

Repatha® Prior Authorization Request Form (Page 3 of 3)

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Reauthorization:

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

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

Select if Repatha is prescribed by one of the following specialists:

❑ Cardiologist ❑ Endocrinologist ❑ Lipid specialist

Will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has had a reduction in LDL-C levels while on PCSK9 therapy?* ❑ **Yes** ❑ **No**

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

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

Does the prescriber attest to the following: the information provided is true and accurate to the best of their knowledge and they understand that OptumRx may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided? ❑ **Yes** ❑ **No**

For primary hyperlipidemia(HeFH and/or ASCVD), also answer the following:

Does the patient continue to receive a statin at the maximally tolerated dose (unless patient has documented inability to take statins)? ❑ **Yes** ❑ **No**

For homozygous familial hypercholesterolemia (HoFH), also answer the following:

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

Will Repatha be used in combination with Juxtapid (lomitapide)? ❑ **Yes** ❑ **No**

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 to 1-800-527-0531.