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

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

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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:

❑ Primary hyperlipidemia
- ❑ Atherosclerotic cardiovascular disease (ASCVD)
- ❑ Heterozygous familial hypercholesterolemia (HeFH)

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

Medication History:

Select if the patient has had trial and failure, contraindication, or intolerance to the following:

❑ Atorvastatin calcium ❑ Lovastatin ❑ Repatha ❑ Simvastatin
❑ Ezetimibe ❑ Pravastatin sodium ❑ Rosuvastatin calcium

Clinical Information:

Select the indication for which this medication is being prescribed:

❑ Heterozygous familial hypercholesterolemia (HeFH) as confirmed by the following:
- ❑ Untreated/pre-treatment LDL-cholesterol (LDL-C) greater than 190 mg/dL as an adult
- ❑ 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 greater than 190 mg/dL in first- or second-degree relative
- ❑ Family history of familial hypercholesterolemia in first- or second-degree relative
- ❑ Family history of tendinous xanthomas and/or arcus cornealis in first- or second-degree relative
- ❑ Presence of tendinous xanthomas in the patient*
- ❑ Arcus cornealis before age 45*
- ❑ Functional mutation in the LDL receptor, ApoB, or PCSK9 gene*

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

❑ Atherosclerotic cardiovascular disease (ASCVD) as confirmed by the following:
- ❑ Acute coronary syndromes
- ❑ History of myocardial infarction
- ❑ Stable or unstable angina
- ❑ Coronary or other arterial revascularization
- ❑ Stroke
- ❑ Transient ischemic attack
- ❑ Peripheral arterial disease presumed to be of atherosclerotic origin

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Select if the patient has one of the following LDL-C values while on maximally tolerated lipid-lowering regimen ***within the last 120 days***:

- ❑ LDL-C between 70 mg/dL and 99 mg/dL with ASCVD**
- ❑ LDL-C greater than or equal to 100 mg/dL with ASCVD
- ❑ LDL-C between 100 mg/dL and 129 mg/dL without ASCVD**
- ❑ LDL-C greater than or equal to 130 mg/dL without ASCVD

***Please note: Treatment with ezetimibe (Zetia) and 1 maximally tolerated statin is required.*

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

Will the patient continue to receive a **high-intensity** statin therapy? ❑ **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 less than 10 times upper limit of normal [ULN])

Has the patient been receiving at least 12 consecutive weeks of one **moderate-intensity or low-intensity** statin therapy [i.e., atorvastatin 10-20 mg, Crestor (rosuvastatin) 5-10 mg, simvastatin 10-40 mg, pravastatin 10-80 mg, lovastatin 20-40 mg, Lescol XL (fluvastatin XL) 80 mg, fluvastatin 20-40 mg, or Livalo (pitavastatin) 1-4 mg] at a maximally tolerated dose? ❑ **Yes** ❑ **No**

Will the patient continue to receive a **moderate-intensity** or **low-intensity** statin therapy? ❑ **Yes** ❑ **No**

Select if the patient is unable to tolerate **moderate-intensity** or **low-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 less than 10 times upper limit of normal [ULN])

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

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

Has the patient experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN on one statin therapy? ❑ **Yes** ❑ **No**

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

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

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

Select if the requested medication is prescribed by or in consultation with one of the following specialists:

- ❑ Cardiologist
- ❑ Endocrinologist
- ❑ Lipid specialist

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

Reauthorization:

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

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

Does the patient have experienced LDL-C reduction while on Praluent therapy as documented by medical records (e.g., laboratory values)?* ❑ **Yes** ❑ **No**

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

Select if the requested medication is prescribed by or in consultation with one of the following specialists:

- ❑ Cardiologist
- ❑ Endocrinologist
- ❑ Lipid specialist

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

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

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

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Quantity Limit:

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
- ❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____
- ❑ 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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.