UnitedHealthcare
Community Plan

Prior Authorization Request Form
Fax Back To: (866) 940-7328
Phone: (800) 310-6826

Specialty Medication Prior Authorization Cover Sheet

(This cover sheet should be submitted along with a Pharmacy Prior Authorization Medication Fax Request Form. Please refer to www.uhccommunityplan.com for medication fax request forms.)

Patient Information

Patient's Name:

Insurance ID: Date of Birth: Height: Weight:

Address: Apartment #:

City: State: Zip Code:

Phone Number: Alternate Phone: Sex: ☐ Male ☐ Female

Provider Information

Provider's Name: Provider ID Number:

Address: City: State: Zip Code:

Suite Number: Building Number:

Phone Number: Fax number:

Provider's Specialty:

Medication Information

Medication: Quantity: ICD10 Code:

Directions: Diagnosis: Refills:

Physician Signature**: Initial here if DAW:

Physician Signature**: By signing above, the physician is providing the specialty pharmacy with a prescription that can be used to facilitate the dispensing and/or coordination of delivery for the requested medication.

Medication Instructions

Has the patient been instructed on how to **Self-Administer**? ☐ Yes ☐ No

Is this medication a **New Start**? ☐ Yes ☐ No

If continuation please provide the following: Initiation Date: / / Date of Last Dose: / /

Is there documentation of positive clinical response to current therapy? ☐ Yes ☐ No

****Please attach any pertinent clinical information that would pertain to support stated diagnosis. Additional clinical information may be needed depending on your patients plan, including medication(s) previously tried and failed.**

Delivery Instructions

Note: Delivery coordination requires a "**Physician Signature**" above and complete "**Provider Information**" and "**Patient Information**"
Note: All necessary ancillary supplies are provided free of charge to the patient at the time of delivery

Ship to: Physician's Office ☐ Patient's Address ☐ Date medication is needed: / /

Medication Administered: Home Health ☐ Self-Administered ☐ LTC ☐ Physician's Office ☐

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UnitedHealthcare Community Plan

Antihyperlipidemics, PCSK9 Inhibitors - Washington

PRIOR AUTHORIZATION REQUEST FORM

Please complete this entire form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision. Allow at least 24 hours for review.

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS:

- What is the patient's diagnosis? (check which applies)
- □ Heterozygous familial hypercholesterolemia (HeFH)
- □ Primary hypercholesterolemia with atherosclerotic cardiovascular disease (ASCVD)
- □ Homozygous Familial Hypercholesterolemia (HoFH)
- □ Reducing the risk of myocardial infarction, stroke, and coronary revascularization in adults with established cardiovascular disease (CVD)
- □ None of the above, **List diagnosis**: ____________________

- Does the patient have concomitant therapy with the highest-tolerated statin regimen for at least 6 consecutive weeks or is statin intolerant? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- Has the patient's LDL achieved at least 50% reduction from baseline? (since being on the highest-tolerated statin regimen for at least 6 consecutive weeks) □ Yes □ No
If yes, List LDL reduction from baseline: ____________________

- Has the patient's LDL remained ≥100mg/dL? (since being on the highest-tolerated statin regimen for at least 6 consecutive weeks) □ Yes □ No If yes, List LDL: ____________________

- Will the requested medication be used in combination with either of the following: □ Yes □ No (check which applies)
- □ Another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor
- □ Juxtapid (lomitapide)
- □ Kynamro (mipomersen)

- Is the requested medication being prescribed by, or in consultation with, a provider specializing in lipid management? (e.g. cardiologist, lipid specialist, or endocrinologist) □ Yes □ No

- Has the patient demonstrated failure or intolerance to one preferred Antihyperlipidemics - PCSK9 Inhibitor? (check which applies) □ Yes □ No □ N/A (No preferred formulary alternative available)
(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)
If no, list reason: ____________________

Requests for HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH):

- Has the patient's diagnosis been defined by one of the following: □ Yes □ No (check which applies)
- □ Clinical diagnosis using diagnostic tools such as US MedPed, Simon Broome Register Group, or Dutch Lipid Panel
  List diagnostic tool: ____________________
- □ Age ≥20 and LDL ≥190mg/dL on maximally tolerated statin therapy prior to adding a PCSK9 Inhibitor
  List age / LDL / statin and dose: ____________________
- □ Age <20 and LDL ≥160mg/dL on maximally tolerated statin therapy prior to adding a PCSK9 Inhibitor
  List age / LDL / statin and dose: ____________________
- □ Genetic typing confirming presence of familial hypercholesterolemia genes
- □ None of the above List: ____________________

Requests for HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HOFH):

- Has the patient's diagnosis been defined by one of the following: □ Yes □ No (check which applies)
- □ History of untreated LDL ≥500mg/dL with a xanthoma before 10 years of age
  List LDL / age of xanthoma: ____________
- □ Evidence of heterozygous familial hypercholesterolemia in both parents: ____________________
- □ Genetic typing confirming presence of familial hypercholesterolemia genes
- □ None of the above, List: ____________________

UnitedHealthcare Community Plan

Antihyperlipidemics, PCSK9 Inhibitors - Washington

PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

- Has the patient's LDL remained ≥130mg/dL? (since being on the highest-tolerated statin regimen for at least 6 consecutive weeks) □ Yes □ No If yes, List LDL: ______

Requests for PRIMARY HYPERCHOLESTEROLEMIA WITH ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD) & REDUCING THE RISK OF MYOCARDIAL INFARCTION, STROKE, AND CORONARY REVASCULARIZATION IN ADULTS WITH ESTABLISHED CARDIOVASCULAR DISEASE (CVD):

- Does the patient have history of at least one of the following: □ Yes □ No (check which applies)

□ Myocardial infarction (MI), presumed to be of atherosclerotic origin
□ Acute coronary syndrome (ACS), presumed to be of atherosclerotic origin
□ Severe angina, presumed to be of atherosclerotic origin
□ Stroke, presumed to be of atherosclerotic origin
□ Transient ischemic attack (TIA), presumed to be of atherosclerotic origin
□ Coronary revascularization procedures, presumed to be of atherosclerotic origin
□ Peripheral arterial disease, presumed to be of atherosclerotic origin
□ None of the above, List: ______________________________

Requests for CONTINUATION OF THERAPY:

- Does the patient continue to receive the maximum tolerated dose of statin, unless contraindicated or intolerant to statin therapy? □ Yes □ No
If yes, list statin / dose: ______________________________

- Is there documentation of continued clinical benefit? (e.g. at least a 30% reduction in LDL from initiation of PCSK9 Inhibitor or achievement of patient-specific goal) □ Yes □ No
If yes, list clinical benefit: ______________________________

Physician Signature: ______________________________ Date: ______________

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