Prior Authorization Form

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested authorization(s). Attach additional sheets to this form if necessary.

Please fax the completed PA form and any additional informational sheets to Nirvanahealth at the following fax number: +1(866) 871-8565

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Health Plan Name:		Prescriber Address:	
Patient Insurance Id:			
Patient Date of Birth:		Prescriber Phone:	( )
Patient Phone:		Prescriber Fax:	( )
		Prescriber Specialty:	
		Prescriber DEA:	
		Prescriber NPI:	

Medication & Medical Information	
Requested Drug(s) & Strength(s):	[ ] Praluent Pen 150 mg/mL subcutaneous pen injector [ ] Praluent Pen 75 mg/mL subcutaneous pen injector
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – Days:	
Expected Length of Therapy:	
Directions:	
Diagnosis and Diagnosis Codes (ICD-10 Standard Codes):	
List drugs used previously to treat the same condition:	
Additional clinical information or history. Please include any relevant test results and/or medical record notes:	

Questionnaire

Q1: I, as the provider or designated representative of the provider, certify and attest that the information provided is complete and accurate and that, upon request, I shall provide any information to RxAdvance that RxAdvance determines is reasonably necessary to verify my responses. (Check only one that apply)

[ ] Yes

[ ] No

Q2: Is the requested medication prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist? (Check only one that apply)

[ ] Yes (please specify prescriber specialty) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q3: Is the member currently treated with this medication? (Check only one that apply)

[ ] Yes (please list start date of therapy (month/day/year)) _____ (*Required)

[ ] No

Q4: What is the member's diagnosis? (Check only one that apply)

[ ] Heterozygous familial hypercholesterolemia (HeFH)

[ ] Atherosclerotic cardiovascular disease (ASCVD)

[ ] Primary hyperlipidemia (HLD)

[ ] Homozygous familial hypercholesterolaemia (HoFH)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q5: Does the member continues to receive other lipid-lowering treatment (e.g. statins, ezetimibe)? (Check only one that apply)

[ ] Yes (please specify drug name) _____(*Required)

[ ] No

Q6: Does the member have a documented inability to take other lipid-lowering treatment (e.g. statin, ezetimibe)? (Check only one that apply)

[ ] Yes (please provide supporting documents) _____(*Required)

[ ] No (please provide medical justification for continuation of therapy) _____(*Required)

Q7: Does the member have submitted medical records (e.g., lab values) documenting LDL reduction while on Praluent therapy? (Check only one that apply)

[ ] Yes (please provide supporting documents) _____(*Required)

[ ] No (please provide medical justification for continuation of therapy) _____(*Required)

Q8: What is the member's diagnosis? (Check only one that apply)

[ ] Heterozygous familial hypercholesterolemia (HeFH)

[ ] Atherosclerotic cardiovascular disease (ASCVD)

[ ] Primary hyperlipidemia (HLD)

[ ] Homozygous familial hypercholesterolaemia (HoFH)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q9: Does the member have untreated/pre-treatment LDL greater than 190 mg/dL in an adult? (Check only one that apply)

[ ] Yes (please specify LDL value and date of test) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q10: Does the member's diagnosis confirmed by any one of the following (please provide supporting documents)? (Check only one that apply)

[ ] Family history of tendinous xanthomas and/or arcus cornealis in 1st degree relative, or 2nd degree relative

[ ] History of myocardial infarction (MI) in 1st-degree relative less than 60 years of age

[ ] Family history of myocardial infarction (MI) in 2nd-degree relative less than 50 years of age

[ ] Family history of LDL-C greater than 190 mg/dL in 1st- or 2nd-degree relative

[ ] Family history of Familial hypercholesterolemia (FH) in 1st- or 2nd-degree relative

[ ] None of the above

Q11: Does the member have submitted medical records (eg chart notes, lab values) documenting one of the following (please provide supporting documents)? (Check only one that apply)

[ ] Presence of tendinous xanthoma

[ ] Presence of arcus cornealis before member's age 45 years

[ ] Functional mutation in the LDL receptor ApoB gene

[ ] Functional mutation in the LDL receptor PCSK9 gene

[ ] None of the above (please provide clinical rationale for the request)
_____(*Required)

Q12: Does the member's diagnosis confirmed by any one of the following (please provide supporting documents)? (Check only one that apply)

[ ] Acute coronary syndrome (ACS)

[ ] History of myocardial infarction (MI)

[ ] Stable or unstable angina

[ ] Coronary or other arterial revascularization

[ ] Stroke

[ ] Transient ischaemic attack (TIA)

[ ] Peripheral arterial disease presumed to be of atherosclerotic origin

[ ] None of the above (please provide clinical rationale for the request)
_____(*Required)

Q13: Does the member have submitted medical records (e.g., chart notes, lab values) documenting diagnosis of Homozygous familial hypercholesterolaemia (HoFH) as evidenced by genetic confirmation of 2 mutations in LDL receptor, ApoB, PCSK9, or LDLRAP1 or ARH? (Check only one that apply)

[ ] Yes (please provide supporting documents) _____(*Required)

[ ] No

Q14: Does the member have submitted medical records (e.g., chart notes, lab values) documenting diagnosis of Homozygous familial hypercholesterolaemia (HoFH) as confirmed by either untreated LDL greater than 500 or treated LDL greater than 300? (Check only one that apply)

[ ] Yes (please provide supporting documents) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q15: Has the member had xanthoma before 10 years of age? (Check only one that apply)

[ ] Yes (please provide supporting documents) _____(*Required)

[ ] No

Q16: Does the member have evidence of Heterozygous familial hypercholesterolemia (HeFH) in both parents? (Check only one that apply)

[ ] Yes (please provide supporting documents) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q17: Does the member is receiving other lipid-lowering treatment (e.g. statins, ezetimibe)? (Check only one that apply)

[ ] Yes (please specify drug name and start date of therapy) _____ (*Required)

[ ] No

Q18: Does the member have a documented inability to take other lipid-lowering treatment (e.g. statin, ezetimibe)? (Check only one that apply)

[ ] Yes (please provide supporting documents) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q19: Does the member have LDL greater than or equal to 100 mg/dL with Atherosclerotic cardiovascular disease (ASCVD), while on max tolerated lipid lowering regimen within the last 120 days? (Check only one that apply)

[ ] Yes (please specify LDL value and date of Lab test) _____ (*Required)

[ ] No

Q20: Does the member have LDL greater than or equal to 130 mg/dL without Atherosclerotic cardiovascular disease (ASCVD), while on max tolerated lipid lowering regimen within the last 120 days? (Check only one that apply)

[ ] Yes (please specify LDL value and date of Lab test) _____ (*Required)

[ ] No

Q21: Has the member been receiving at least 12 weeks of one high-intensity (HI) statin therapy and will continue to receive a HI statin [i.e., atorvastatin 40-80 mg, rosuvastatin 20-40 mg] at max tolerated dose? (Check only one that apply)

[ ] Yes (please specify name of drug and start date of therapy (MM/DD/YY))
_____(*Required)

[ ] No

Q22: Is the member unable to tolerate high-intensity (HI) statin as evidenced by intolerable and persistent (i.e., more than 2 weeks) myalgia (muscle symptoms without Creatine kinase (CK) elevations) or myositis (muscle symptoms with Creatine kinase (CK) elevations less than 10 times upper limit of normal (ULN))? (Check only one that apply)

[ ] Yes (please provide supporting medical records) _____ (*Required)

[ ] No

Q23: Has the member been receiving at least 12 weeks of one moderate-intensity (MI) or low-intensity (LI) statin therapy and will continue to receive a moderate-intensity (MI) or low-intensity (LI) statin [i.e., atorvastatin 10-20 mg, 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 max tolerated dose? (Check only one that apply)

[ ] Yes (please specify name of drug and start date of therapy (MM/DD/YY))
_____(*Required)

[ ] No

Q24: Is the member unable to tolerate moderate-intensity (MI) or low-intensity (LI) statin as evidenced by intolerable and persistent (i.e., more than 2 weeks) myalgia (muscle symptoms without Creatine kinase (CK) elevations) or myositis (muscle symptoms with Creatine kinase (CK) elevations less than 10 times upper limit of normal (ULN))? (Check only one that apply)

[ ] Yes (please provide supporting medical records) _____ (*Required)

[ ] No

Q25: Does the member have a labeled contraindication to all statins? (Check only one that apply)

[ ] Yes

[ ] No

Q26: Has the member experienced rhabdomyolysis or muscle symptoms with statin treatment with Creatine kinase (CK) elevations greater than 10 times upper limit of normal (ULN)) on one statin therapy? (Check only one that apply)

[ ] Yes (please provide supporting documents) _____(*Required)

[ ] No

Q27: Does the member have LDL between 70 and 99 mg/dL with Atherosclerotic cardiovascular disease (ASCVD), while on max tolerated lipid lowering regimen within the last 120 days? (Check only one that apply)

[ ] Yes (please specify LDL value and date of Lab test) _____ (*Required)

[ ] No

Q28: Does the member have LDL between 100 and 129 mg/dL without Atherosclerotic cardiovascular disease (ASCVD), while on max tolerated lipid lowering regimen within the last 120 days? (Check only one that apply)

[ ] Yes (please specify LDL value and date of Lab test) _____ (*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q29: Has the member been receiving at least 12 wks of one max-tolerated statin therapy and will continue to receive a statin at max tolerated dose? (Check only one that apply)

[ ] Yes (please specify name of drug and start date of therapy (MM/DD/YY))
_____(*Required)

[ ] No

Q30: Is the member unable to tolerate statin therapy as evidenced by intolerable and persistent (i.e., more than 2 weeks) myalgia (muscle symptoms without Creatine kinase (CK) elevations) or myositis (muscle symptoms with Creatine kinase (CK) elevations less than 10 times upper limit of normal (ULN)? (Check only one that apply)

[ ] Yes (please provide supporting medical records) _____ (*Required)

[ ] No

Q31: Does the member have a labeled contraindication to all statins? (Check only one that apply)

[ ] Yes

[ ] No

Q32: Has the member experienced rhabdomyolysis or muscle symptoms with statin treatment with Creatine kinase (CK) elevations greater than 10 times upper limit of normal (ULN)) on one statin therapy? (Check only one that apply)

[ ] Yes (please provide supporting documents) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q33: Has the member been receiving at least 12 weeks of ezetimibe (Zetia) therapy as adjunct to max tolerated statin therapy? (Check only one that apply)

[ ] Yes (please provide supporting documents) _____(*Required)

[ ] No

Q34: Does the member have a history of contraindication or intolerance to ezetimibe? (Check only one that apply)

[ ] Yes (please specify experienced contraindicaton or intolerance) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group or its designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.	
Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	