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):	[ ] Repatha Syringe 140 mg/mL subcutaneous syringe
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 member currently treated with this medication? (Check only one that apply)

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

[ ] No

Q3: What is the member's diagnosis? (Check only one that apply)

[ ] Heterozygous familial hypercholesterolemia (HeFH)

[ ] Atherosclerotic cardiovascular disease (ASCVD)

[ ] Primary hyperlipidemia (HDL)

[ ] Homozygous familial hypercholesterolemia (HoFH)

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

Q4: Does the member have medical records (e.g., chart notes, laboratory values) to support the member has had a reduction in LDL-C levels while on Repatha therapy? (Check only one that apply)

[ ] Yes (please specify the lab test, the date for lab test and lab values)
_____(*Required)

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

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

[ ] Yes (please specify drug name and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] No

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

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

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

Q7: Is the requested drug prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist? (Check only one that apply)

[ ] Yes (please specify which type of specialist) _____(*Required)

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

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

[ ] Heterozygous familial hypercholesterolemia (HeFH)

[ ] Atherosclerotic cardiovascular disease (ASCVD)

[ ] Primary hyperlipidemia (HDL)

[ ] Homozygous familial hypercholesterolemia (HoFH)

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

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

[ ] Yes (please specify LDL-C levels and date of lab test (month/year))
_____(*Required)

[ ] No

Q10: Does the member have family history of tendinous xanthomas and/or arcus cornealis in 1st degree relative, or 2nd degree relative? (Check only one that apply)

[ ] Yes (please specify the family history(s) and 1st or 2nd degree relative)
_____(*Required)

[ ] No

Q11: Does the member have history of myocardial infarction in 1st-degree relative less than 60 years of age? (Check only one that apply)

[ ] Yes (please specify 1st degree and relative's age) _____
(*Required)

[ ] No

Q12: Does the member have family history of myocardial infarction in 2nd-degree relative less than 50 years of age? (Check only one that apply)

[ ] Yes (please specify 2nd degree and relative's age) _____
(*Required)

[ ] No

Q13: Does the member have family history of LDL-C greater than 190 mg/dL in 1st or 2nd degree relative? (Check only one that apply)

[ ] Yes (please specify LDL-C levels, date of lab test (month/year) and 1st or 2nd degree relative)
_____(*Required)

[ ] No

Q14: Does the member have family history of familial hypercholesterolemia in 1st or 2nd degree relative? (Check only one that apply)

[ ] Yes (please specify 1st or 2nd degree relative) _____(*Required)

[ ] No

Q15: If the member have medical records (e.g., chart notes, lab values) documenting untreated or pre-treatment LDL greater than 190 mg/dL in an adult as confirmed by which one of the following: (Check only one that apply)

[ ] Presence of tendinous xanthoma in member

[ ] Arcus cornealis before age 45

[ ] Functional mutation in the LDL receptor, ApoB, or PCSK9 gene

[ ] Other (please provide clinical rationale for the request) _____
(*Required)

Q16: Is the member at least 10 years old? (Check only one that apply)

[ ] Yes

[ ] No (please specify member's age and provide clinical rationale for the request)
_____(*Required)

Q17: Member's diagnosis is confirmed by which one of the following: (Check only one that apply)

[ ] Acute coronary syndrome

[ ] 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.

[ ] Other (please provide clinical rationale for the request) _____ (*Required)

Q18: Select one of the following LDL values while member on lipid lowering agent within the last 120 days: (Check only one that apply)

[ ] LDL greater than or equal to 100 mg/dL with atherosclerotic cardiovascular disease (please specify LDL levels and date of lab test (month/year)) _____(*Required)

[ ] LDL greater than or equal to 130 mg/dL without atherosclerotic cardiovascular disease (please specify LDL levels and date of lab test (month/year)) _____(*Required)

[ ] LDL between 70 and 99 mg/dL with atherosclerotic cardiovascular disease (please specify LDL levels and date of lab test (month/year)) _____(*Required)

[ ] LDL between 100 and 129 mg/dL without atherosclerotic cardiovascular disease (please specify LDL levels and date of lab test (month/year)) _____(*Required)

[ ] Other (please specify LDL levels and date of lab test (month/year))
_____(*Required)

Q19: Has the member been receiving at least 12 weeks of one high-intensity statin therapy and will continue to receive a high-intensity statin [i.e., atorvastatin 40-80 mg, rosuvastatin 20-40 mg] at maximum tolerated dose? (Check only one that apply)

[ ] Yes (please specify drug name and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] No

Q20: Select if the member unable to tolerate high-intensity statin therapy as evidenced by one of the following intolerable and persistent (i.e., more than 2 weeks) symptoms: (Check only one that apply)

[ ] Myalgia (muscle symptoms without CK elevations)

[ ] Myositis (muscle symptoms with CK elevations < 10 times the upper limit of normal)

[ ] Other (please provide clinical rationale for the request) _____ (*Required)

Q21: Has the member been receiving at least 12 weeks of one moderate-intensity or low-intensity statin therapy and will continue to receive a moderate-intensity or low-intensity 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 maximum tolerated dose? (Check only one that apply)

[ ] Yes (please specify drug name and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] No

Q22: Select if the member 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: (Check only one that apply)

[ ] Myalgia (muscle symptoms without CK elevations)

[ ] Myositis (muscle symptoms with CK elevations < 10 times the upper limit of normal)

[ ] Other (please provide clinical rationale for the request) _____ (*Required)

Q23: Does the member have a labeled contraindication to all statins? (Check only one that apply)

[ ] Yes (please specify drug name(s), corresponding contraindication(s) experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No

Q24: Has the member experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times upper limit of normal on one statin therapy? (Check only one that apply)

[ ] Yes (please specify drug name, corresponding symptom(s) and the start and end date(s) of therapy (month/year)) _____(*Required)

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

Q25: Has the member been receiving at least 12 weeks of one statin therapy and will continue to receive a statin? (Check only one that apply)

[ ] Yes (please specify drug name and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No

Q26: Select if the member unable to tolerate statin therapy as evidenced by one of the following intolerable and persistent (i.e., more than 2 weeks) symptoms: (Check only one that apply)

[ ] Myalgia (muscle symptoms without CK elevations)

[ ] Myositis (muscle symptoms with CK elevations < 10 times the upper limit of normal)

[ ] Other (please provide clinical rationale for the request) _____ (*Required)

Q27: Does the member have a labeled contraindication to all statins? (Check only one that apply)

[ ] Yes (please specify drug name(s), corresponding contraindication(s) experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No

Q28: Has the member experienced rhabdomyolysis or muscle symptoms with statin therapy with CK elevations greater than 10 times upper limit of normal on one statin therapy? (Check only one that apply)

[ ] Yes (please specify drug name, corresponding symptom(s) and the start and end date(s) of therapy (month/year)) _____(*Required)

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

Q29: Has the member been receiving at least 12 weeks of ezetimibe (Zetia) therapy as adjunct to statin therapy? (Check only one that apply)

[ ] Yes (please specify the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] No

Q30: Does the member have a history of contraindication or intolerance to ezetimibe? (Check only one that apply)

[ ] Yes (please specify contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year))
_____(*Required)

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

Q31: Does the member have genetic confirmation of 2 mutations in LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1 (i.e., LDLRAP1 or ARH)? (Check only one that apply)

[ ] Yes (please specify mutations type and date of test) _____
(*Required)

[ ] No

Q32: Does the member have untreated LDL greater than 500? (Check only one that apply)

[ ] Yes (please specify LDL levels and date of lab test (month/year))
_____(*Required)

[ ] No

Q33: Does the member have treated LDL greater than 300? (Check only one that apply)

[ ] Yes (please specify LDL levels and date of lab test (month/year))
_____(*Required)

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

Q34: Does the member have xanthoma before 10 year old? (Check only one that apply)

[ ] Yes

[ ] No

Q35: Does the member have evidence of heterozygous familial hypercholesterolemia in both parents? (Check only one that apply)

[ ] Yes

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

Q36: Is member receiving other lipid-lowering therapy (e.g., statin, ezetimibe)? (Check only one that apply)

[ ] Yes (please specify drug name and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] No

Q37: Does the member have a documented inability to take other lipid-lowering therapy (e.g., statin, ezetimibe)? (Check only one that apply)

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

[ ] No

Q38: Is the member at least 10 years old? (Check only one that apply)

[ ] Yes

[ ] No (please specify member's age and provide clinical rationale for the request)
_____(*Required)

Q39: Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist? (Check only one that apply)

[ ] Yes (please specify which type of specialist) _____(*Required)

[ ] No (please provide clinical rationale for 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:	