Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization
Hyperlipidemia Agents: evolocumab (REPATHA)

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** ☐ **Standard (Non-Urgent)** *Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :	Specialty:	
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:

1. Medication Requested (Name):
(Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

Clinical Criteria (required)

6. Has the provider submitted a Prior Authorization (PA) form for the request?

- ◯ Yes
(Go to #7)
- ◯ No (Deny)
(Go to #7)

7. Is the member greater than or equal to (≥) ten (10) years of age?

- ◯ Yes
  (Go to #8)
- ◯ No (Deny)
  (Go to #8)

8. Does the member have a diagnosis of homozygous familial hypercholesterolemia (HoFH) in the last 730 days?

- ◯ Yes
  (Go to #9)
- ◯ No
  (Go to #10)

9. Is the prescribed dose less than or equal to (≤) 420mg every two (2) weeks?

- ◯ Yes
  (Go to #16)
- ◯ No (Deny)
  (Go to #10)

10. Does the member have a diagnosis of heterozygous familial hypercholesterolemia (HeFH) in the last 730 days?

- ◯ Yes
  (Go to #14)
- ◯ No
  (Go to #11)

11. Is the member greater than or equal to (≥) 18 years of age?

- ◯ Yes
  (Go to #12)
- ◯ No (Deny)
  (Go to #12)

12. Does the member have a diagnosis of primary hyperlipidemia in the last 730 days?

- ◯ Yes
  (Go to #14)
- ◯ No
  (Go to #13)

13. Does the member have a diagnosis clinical atherosclerotic cardiovascular disease (ASCVD) in the last 730 days?

- ◯ Yes
  (Go to #14)
- ◯ No (Deny)
  (Go to #14)

14. Is the prescribed dose equal to 140mg every two (2) weeks?

- ◯ Yes
  (Go to #16)
- ◯ No
  (Go to #15)

15. Is the prescribed dose equal to 420mg every four (4) weeks?

- ◯ Yes
  (Go to #16)
- ◯ No (Deny)
  (Go to #16)

16. Does the member have a concurrent claim for atorvastatin (LIPITOR) or rosuvastatin (CRESTOR)?

- ◯ Yes
  (Go to #17)
- ◯ No (Deny)
  (Go to #17)

17. Does the member have one (1) claim for alirocumab (PRALUENT) or evolocumab (REPATHA) in the last 90 days?

- ◯ Yes
  (Go to #18)
- ◯ No
  (Go to #19)

18. Has the member shown clinical response (significant lowering of low-density lipoprotein cholesterol (LDL-C)*) since initiation of proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor therapy? [Manual Step]

*Significant lowering of LDL-C is defined as a 30% decrease in LDL for members with a diagnosis of homozygous familial hypercholesterolemia and a 50% decrease in LDL for members with a diagnosis of primary hyperlipidemia and/or clinical ASCVD

- ◯ Yes (Approve - 180 days)
  (Go to #21)
- ◯ No (Deny)
  (Go to #19)

19. Does the member have at least 90 consecutive days of high dose atorvastatin therapy, 90 consecutive days of high dose rosuvastatin therapy, and 90 consecutive days of ezetimibe (ZETIA) therapy in the last 730 days?

Examples of high dose statin therapy include 40mg to 80mg doses of atorvastatin (LIPITOR) and 20mg to 40mg of rosuvastatin (CRESTOR, EZALLOR SPRINKLE).

- ◯ Yes
  (Go to #20)
- ◯ No (Deny)
  (Go to #20)

20. Does the member have a documented low-density lipoprotein cholesterol (LDL-C) of greater than (>) 70mg/dL? [Manual Step]

- ◯ Yes (Approve - 180 days)
  (Go to #21)
- ◯ No (Deny)
  (Go to #21)

Additional Information

21. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

**** PLEASE FAX COMPLETED FORM TO: 855-668-8553 ****

If criteria not met, submit chart documentation with form citing complex medical circumstances.
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