TEXAS MEDICAID
Clinical Edit Prior Authorization
alirocumab (PRALUENT)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: MEDICATION INFORMATION	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Please indicate ONE (1) of the following:

☐ STAR / STAR KIDS client **(Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ CHIP / PERINATE client **(Go to Step 4)**

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 30-day treatment trial with atorvastatin, rosuvastatin and ezetimibe in the last 180 days?

   ☐ Yes (Go to #2) ☐ No (Go to #3)

2. Will the client have concurrent therapy with atorvastatin or rosuvastatin?

   ☐ Yes (Go to Step 4, Question 1) ☐ No (Go to #3)

3. Is there a documented allergy or contraindication to preferred agents in this class?

   ☐ Yes (Go to Step 4, Question 1) ☐ No (Go to #4)

4. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

☐ Yes (Go to Step 4, Question 1) ☐ No (Deny)

STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

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

☐ Yes (Go to #2) ☐ No (Deny)

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

☐ Yes (Go to #3) ☐ No (Deny)

3. Does the client have a diagnosis of primary hyperlipidemia in the last 730 days?

☐ Yes (Go to #5) ☐ No (Go to #4)

4. Does the client have a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) in the last 730 days?

☐ Yes (Go to #5) ☐ No (Deny)

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

☐ Yes (Go to #6) ☐ No (Deny)

6. Does the client have 1 claim for alirocumab (PRALUENT) or evolocumab (REPATHA) in the last 90 days?

☐ Yes (Go to #7) ☐ No (Go to #8)

7. Has the client 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]

☐ Yes (Approve – 180 days) ☐ No (Deny)

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

8. Does the client 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 #9) ☐ No (Deny)

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

   ☐ Yes (Approve – 180 days) ☐ No (Deny)

STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

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

For questions, please call Navitus Customer Care at 1-877-908-6023.