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

TEXAS MEDICAID

Drug Prior Authorization
Hyperlipidemia Agents: alirocumab (PRALUENT)

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 (≥) 18 years of age?

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

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

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

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

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

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

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

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

- ◯ Yes
  (Go to #12)
- ◯ No
  (Go to #13)

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

**Significiant 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.*

- ◯ Yes (Approve - 180 days)
  (Go to #15)
- ◯ No (Deny)
  (Go to #13)

13. 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 therapy in the last 730 days?

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

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

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

- ◯ Yes (Approve - 180 days)
  (Go to #15)
- ◯ No (Deny)
  (Go to #15)

Additional Information

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

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

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