



HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Repatha- Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Form with two columns: Patient Name and Prescriber Name. Fields include Member Number, Date of Birth, Line of Business, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, State Lic ID, Address, City, State ZIP, and Specialty/facility name.

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:
Strength:
Directions / SIG:

Please attach any pertinent medical history including labs and information for this member that may support approval. Please answer the following questions and sign.

Q1. Is Repatha being prescribed by or in consultation with an appropriate specialist (cardiologist, endocrinologist, or lipidologist)?

Yes No

Q2. Does the patient have the diagnosis of homozygous familial hypercholesterolemia as defined by one of the following?
A) Genetic confirmation of 2 mutant alleles in the low density lipoprotein (LDL) receptor, ApoB-100 or proprotein convertase subtilisin/kexin type 9 (PCSK9) gene
B) Untreated low density lipoprotein cholesterol (LDL-C) greater than 500 mg/dL
C) Treated LDL-C greater than or equal to 300 mg/dL with cutaneous or tendinous xanthoma before the age of 10, or
D) Untreated LDL-C levels consistent with heterozygous familial hypercholesterolemia in both parents (greater than 190 mg/dL)

Must attach documentation.
If No, go to 5.

Yes No

Q3. Is the patient 13 years of age or older?

Yes No

Q4. Is the patient being prescribed 420 mg of Repatha once per month?
If yes, go to 8.

Yes No

Q5. Is the patient 18 years of age or older?



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Patient Name:

Prescriber Name:

Yes checkbox

No checkbox

Q6. Does the patient have the diagnosis of heterozygous familial hypercholesterolemia (HeFH) as defined by one of the following?
A) Genetic confirmation of a mutation in the low density lipoprotein (LDL) receptor, Apo B-100 or proprotein convertase subtilisin/kexin type 9 (PCSK9) gene
B) Dutch Lipid Network Criteria with a score greater than 6 points
Must attach documentation.
If Yes, go to 8.

Yes checkbox

No checkbox

Q7. Does the patient have primary hyperlipidemia or clinical atherosclerotic cardiovascular disease (ASCVD)? If yes, please attach documentation

Yes checkbox

No checkbox

Q8. Has the patient had a prior treatment history with at least one high intensity statin (atorvastatin 40 mg or 80 mg OR rosuvastatin 20 mg or 40 mg) AND ezetimibe for at least 3 continuous months with failure to reach target low density lipoprotein cholesterol (LDL-C) levels?
If Yes, go to 12.

Yes checkbox

No checkbox

Q9. Has the patient experienced statin-associated side effects? Must attach documentation.
If Yes, go to 11.

Yes checkbox

No checkbox

Q10. Does the patient have a condition that would be considered a contraindication to statin therapy, including active liver disease, or persistent elevation of serum transaminases?

Yes checkbox

No checkbox

Q11. Have either baseline labs or post-treatment labs (lipid profile) been attached?

Yes checkbox

No checkbox

Q12. Is this a request for a continuation of therapy?

Yes checkbox

No checkbox

Q13. Additional Information:

Q14. Duration:

Initial Request - 6 months checkbox

Continuation Request - 12 months checkbox



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Patient Name:

Prescriber Name:

Prescriber Signature

Date

2021 Medicare Prior Authorization Request