DisclosedRx
The Fiduciary and Fully Disclosed PBM®

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Prior Authorization Request Form

PCSK-9 Inhibitors

☐ Standard ☐ Urgent ☐ Reconsideration/Appeal

Patient Information

Patient Name: ______________________ DOB (mm/dd/yyyy): ______________ Gender: ________

Address: ______________________ City: ______________________ State & Zip: ____________

Cardholder ID: ______________________ Group #: ______________________ Relationship Code: ________

Phone Number: ______________________ Email address: ______________________________

Prescriber Information

Prescriber Name: ______________________ Specialty: ______________________ NPI: ______________

Address: ______________________ City: ______________________ State & Zip: ____________

Office Contact: ______________________ Phone Number: __________________ Fax Number: ____________

Medication Information

Drug Name: ________________________________ Strength: ____________ Quantity: ______________

Directions: ____ Day Supply: ____________

Indicate Request Type: ☐ New Start ☐ Renewal Therapy Start Date (if applicable): ____________________

Diagnosis: ______________________ ICD 10 Code: ____________________

Prior Authorization Request Information

****Supporting documentation (i.e., chart notes, labs, etc.) must be attached to avoid processing delays****

For initial requests:

1. Please select the patient's diagnosis:

☐ Homozygous familial hypercholesterolemia (HoFH) – must select one of the following: ☐ N/A
- ☐ Genetic variant at the LDLR, Apo-B, PCSK9, or 1/LDLRAP1 gene
- ☐ History of cutaneous or tendon xanthomas before age of 10 years

☐ Heterozygous familial hypercholesterolemia (HeFH) – must select one of the following: ☐ N/A
- ☐ Genetic variant at the LDLR, Apo-B, PCSK9, or 1/LDLRAP1 gene
- ☐ History of myocardial infarction in first-degree relative < 60 years or second-degree relative < 50 years
- ☐ History of HeFH, HoFH, tendinous xanthomata, and/or arcus cornealis in first or second-degree relative

☐ Primary Hyperlipidemia – must select one of the following: ☐ N/A
- ☐ Familial hypercholesterolemia ☐ Familial hypertriglyceridemia

☐ Diagnosis of Atherosclerotic Cardiovascular Disease (ASCVD) – must select one of the following: ☐ N/A
- ☐ Acute coronary syndrome ☐ History of myocardial infarction ☐ Stable or unstable angina
- ☐ Stroke ☐ Coronary/Peripheral artery disease ☐ Transient ischemic attack
- ☐ Peripheral artery disease ☐ Other: ________________________________

☐ Other: ________________________________

Please continue to the next page.

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Patient Name:	DOB:

2. **Will the requested agent be used in combination with be used concomitantly with another PCSK-9 inhibitor?** ☐ **Yes** ☐ **No**
3. **Does the patient have any FDA contraindications to the requested agent?** ☐ **Yes** ☐ **No**
4. **Will the patient be taking any other medications in combination with the requested agent for the treatment of this diagnosis? If yes, please list:** ______________________________ ☐ **Yes** ☐ **No**
5. **Has the patient had a lipid panel completed within the past 3 months? Must provide results.** ☐ **Yes** ☐ **No**
6. **Has the patient had an inadequate clinical response to at least a 12-week supply of TWO statins at maximally tolerated doses? If yes, please list below.** ☐ **Yes** ☐ **No**
7. **Has the patient had an intolerance or contraindication to at least TWO statins at maximally tolerated doses? Please submit documentation** ☐ **Yes** ☐ **No**
   ☐ **Muscle systems with CK elevations >10x ULN** ☐ **Myalgia** ☐ **Myositis** ☐ **Rhabdomyolysis**

Drug Name/Strength:	Start Date:	End Date:	Outcome:

For Renewal Requests:
1. **Has the patient had a positive clinical response to therapy? Must submit lipid results from within the past 3 months.** ☐ **Yes** ☐ **No**
2. **Will the requested agent be used in combination with be used concomitantly with another PCSK-9 inhibitor?** ☐ **Yes** ☐ **No**
3. **Does the patient have any FDA contraindications to the requested agent?** ☐ **Yes** ☐ **No**

Prescriber Signature: ______________________________ **Date**: ____________________

Authorized Agent's Name: __________________________

Please fax this request to 602-585-0588 or our secure email at care@disclosedrx.com
Mail Requests to: DisclosedRx Clinical Team
PO Box 701 Washington, IN 47501

Additional Comments/Notes:

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