Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Repatha

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health 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.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the 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 this a request for a continuation of therapy?

☐ Yes ☐ No

Q2. Has an updated lipid profile been attached?

☐ Yes ☐ No

Q3. Does the patient have a diagnosis of Homozygous Familial Hypercholesterolemia as defined by one of the following? Please attach documentation.

a. Genetic confirmation of 2 mutant alleles in the LDL receptor, Apo B- 100 or PCSK9 gene
b. Untreated LDL-C greater than 500 mg/dl
c. Treated LDL-C greater than or equal to 300 mg/dl with cutaneous or tendonous xanthoma before the age of 10
d. Untreated LDL-C levels consistent with heterozygous familial hypercholesterolemia in both parents (greater than 190 mg/dl)

☐ Yes ☐ No

Q4. Is the patient 10 years of age or older?

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Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q5. Is the patient being prescribed 420 mg once a month?

☐ Yes ☐ No

Q6. Does the patient of a diagnosis of heterozygous familial hypercholesterolemia (HeFH) as defined by one of the following? Please attach documentation

a. Genetic confirmation of a mutation in the LDL receptor, Apo B- 100 or PCSK9
b. Dutch Lipid Network Criteria with a score greater than 6 points

☐ Yes ☐ No

Q7. Does the patient have primary hyperlipidemia or clinical atherosclerotic cardiovascular disease (ASCVD)? Please attach documentation.

☐ Yes ☐ No

Q8. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q9. Has the patient had a prior treatment history with at least one high intensity statin therapy (atorvastatin 40 mg or 80 mg or rosuvastatin 20mg or 40 mg) with failure to reach target LDL-C levels?

☐ Yes ☐ No

Q10. Has the patient experienced statin-associated side effects? Please attach documentation.

☐ Yes ☐ No

Q11. 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 ☐ No

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Patient Name:	**Prescriber Name:**

Q12. Have baseline labs (lipid profile) been attached?

☐ Yes ☐ No

Q13. Additional Information:

Prescriber Signature

Date

2024 Prior Authorization Request