Evkeeza

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____

Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Drug Information:
*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Site of Service Questions:

A. Indicate the site of service requested:
- ❑ On Campus Outpatient Hospital ❑ Off Campus Outpatient Hospital
- ❑ Home based setting, *skip to Criteria Questions* ❑ Community office, *skip to Criteria Questions*
- ❑ Ambulatory infusion site, *skip to Criteria Questions*

B. Is the patient less than 18 years of age?
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Has the patient's home been deemed not eligible or appropriate for home infusion services by a home infusion provider? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation. ❑ Yes ❑ No

Criteria Questions:

What is the ICD-10 code? _____

1.Does the patient have a documented diagnosis of homozygous familial hypercholesterolemia?

❒ Yes, *Continue to #2*

❒ No, *Continue to #2*

2. Does the patient possess variant in two low-density lipoprotein receptor (LDLR) alleles? ***ACTION REQUIRED***: Attach genetic testing or supporting medical records.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 8*

❒ No, *Continue to 3*

❒ Unknown, *Continue to 5*

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3. Does the patient have presence of homozygous or compound heterozygous variants in apolipoprotein B (APOB) or proprotein convertase subtilisin-kexin type 9 (PCSK9)? ***ACTION REQUIRED***: Attach genetic testing or supporting medical records.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 8*

❒ No, *Continue to 4*

❒ Unknown, *Continue to 5*

4. Does the patient have compound heterozygosity or homozygosity for variants in the gene encoding low-density lipoprotein receptor adaptor protein 1 (LDLRAP1)? ***ACTION REQUIRED***: Attach genetic testing or supporting medical records.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 8*

❒ No, *Continue to 5*

❒ Unknown, *Continue to 5*

5. What was the patient's untreated (i.e., before treatment with any lipid-lowering therapy) LDL-C level in mg/dL? (Fill in the blank) ***ACTION REQUIRED***: Attach supporting medical records.

❒ Greater than 500 mg/dL _____ mg/dL*, Continue to 7*

❒ Less than or equal to 500 mg/dL _____mg/dL*, Continue to 6*

❒ Unknown, *Continue to 6*

6. What is the patient's treated (i.e., after initiation of lipid-lowering therapy but before treatment with the requested medication) LDL-C level in mg/dL? ***ACTION REQUIRED***: Attach supporting medical records.

❒_____ mg/dL*, Continue to 7*

❒ Unknown, *Continue to 7*

7. Which of the following applies to the patient? ***ACTION REQUIRED***: Attach supporting medical records.

❒ Presence of cutaneous or tendinous xanthomas before the age of 10 years, *Continue to 8*

❒ An untreated LDL-C level of greater than or equal to 190 mg/dL in both parents*, Continue to 8*

❒ Neither - The patient does not meet any of the criteria listed above, *Continue to 8*

❒ Unknown, *Continue to 8*

8. Does the patient have clinical atherosclerotic cardiovascular disease (ASCVD) (e.g., myocardial infarction, acute coronary syndromes, coronary or other arterial revascularization procedure [e.g., percutaneous coronary intervention [PCI], coronary artery bypass graft [CABG] surgery])?

❒ Yes, *Continue to 10*

❒ No, *Continue to 9*

9. Prior to initiation of treatment with the requested medication, what is/was the patient's treated LDL-C level? Indicate LDL-C level in mg/dL. ***ACTION REQUIRED***: Attach medical records indicating LDL-C levels dated within the six months preceding the request.

_____mg/dL*, Continue to 11*

10. Prior to initiation of treatment with the requested medication, what is/was the patient's treated LDL-C level in mg/dL? ***ACTION REQUIRED***: Attach medical records indicating LDL-C levels dated within the six months preceding the request.

_____ mg/dL*, Continue to 11*

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11. What is the patient's age in years?

❒ Less than 5 years of age, *No further questions*

❒ 5 years of age to less than 7 years of age, *Continue to 17*

❒ 7 years of age to less than 10 years of age, *Continue to 14*

❒ 10 years of age or older, *Continue to 12*

12. Prior to initiation of treatment with the requested medication, is/was the patient receiving stable treatment with at least 3 lipid-lowering therapies (for example, statins, ezetimibe, proprotein convertase subtilisin/kexin type 9 [PCSK9] directed therapy) at the maximally tolerated dose? ***ACTION REQUIRED***: Attach chart notes, medical record documentation, or claims history confirming the lipid-lowering therapy.
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Will the patient continue to receive concomitant therapy with 3 lipid-lowering agents (e.g., statins, ezetimibe, proprotein convertase subtilisin/kexin type 9 (PCSK9) directed therapy) at the maximally tolerated dose? ***ACTION REQUIRED***: Attach chart notes, medical record documentation, or claims history confirming the lipid-lowering therapy.
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

14. Prior to initiation of treatment with the requested medication, is/was the patient receiving stable treatment with at least one maximally tolerated lipid-lowering therapy (e.g., statins, LDL apheresis)? ***ACTION REQUIRED***: Attach chart notes, medical record documentation, or claims history confirming the lipid-lowering therapy.
❒ Yes, *Continue to 15*
❒ No, *Continue to 16*

15. Will the patient continue to receive concomitant therapy with one maximally tolerated lipid-lowering therapy (e.g., statins, LDL apheresis)? ***ACTION REQUIRED***: Attach chart notes, medical record documentation, or claims history confirming the lipid-lowering therapy.
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

16. Does the patient have an intolerance or contraindication to other lipid-lowering therapies? ***ACTION REQUIRED***: Attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 18*
❒ No, *No Further Questions*

18. What is the current LDL-C level in mg/dL? ***ACTION REQUIRED***: Attach medical records indicating the current treated LDL-C level. The LDL-C level must be dated within the six months preceding the authorization request.

❒ _____ mg/dL, *Continue to 19*

❒ Unknown, *Continue to 19*

19. Has the patient achieved or maintained an LDL-C reduction as evidenced by either of the following?

❒ LDL-C is now at goal, *Continue to 20*

❒ At least 30% reduction of LDL-C from baseline, *Continue to 20*

❒ None of the above, *Continue to 20*

20. What is the patient's age in years?

❒ Less than 5 years of age, *No further questions*

❒ 5 years of age to less than 7 years of age, *No further questions*

❒ 7 years of age to less than 10 years of age, *Continue to 21*

❒ 10 years of age or older, *Continue to 23*

21. Is the patient currently receiving concomitant lipid-lowering therapy at the maximally tolerated dose? ***ACTION REQUIRED***: Attach chart notes, medical record documentation, or claims history confirming the lipid-lowering therapy.

❒ Yes, *No Further Questions*

❒ No, *Continue to 22*

22. Does the patient have an intolerance or contraindication to other lipid-lowering therapies? ***ACTION REQUIRED***: Attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

23. Is the patient currently receiving concomitant lipid-lowering therapy at the maximally tolerated dose? ***ACTION REQUIRED***: Attach chart notes, medical record documentation, or claims history confirming the lipid-lowering therapy.

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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