*Texas Standard Prior Authorization Form Addendum*

# Molina Healthcare of Texas
## Praluent (Alirocumab) (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Praluent (Medicaid).

| Drug Name (select from list of drugs shown / provide drug information) | |
|---|---|
| PRALUENT 150MG/ML PEN | PRALUENT 75MG/ML PEN |

| Patient Information | |
|---|---|
| Patient Name: | |
| Patient ID: | |
| Patient DOB: | |

| Prescribing Physician | |
|---|---|
| Physician Name: | |
| Physician Phone: | |
| Physician Fax: | |
| Physician Address: | |
| City, State, Zip: | |

| | |
|---|---|
| Diagnosis: | ICD Code: |
| Directions for administration: | |

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   *If the answer to this question is yes, approved for 180 days.*
   *If the answer to this question is no, go to question 2.*

2. Is the patient greater than or equal to 18 years of age? Y N
   *If the answer to this question is yes, go to question 3.*
   *If the answer to this question is no, denied.*

3. Does the patient have a diagnosis of primary hyperlipidemia in the last 730 days? Y N
   *If the answer to this question is yes, go to question 5.*
   *If the answer to this question is no, go to question 4.*

4. Does the patient have a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) in the last 730 days? Y N
   *If the answer to this question is yes, go to question 5.*
   *If the answer to this question is no, denied.*

5. Does the patient have a concurrent claim for atorvastatin or rosuvastatin? Y N

**Concurrent Claim for Atorvastatin or Rosuvastatin:**
Required quantity: 1
Look back timeframe: 90 days
Description -
AMLODIPINE-ATORVASTATIN
ATORVASTATIN
CADUET
CRESTOR
EZALLOR SPRINKLE
LIPITOR
ROSUVASTATIN

*If the answer to this question is yes, go to question 6.*
*If the answer to this question is no, denied.*

6. Does the patient have 1 claim for Praluent or Repatha in the last 90 days? Y N

**Praluent or Repatha therapy:**
Required quantity: 1
Look back timeframe: 90 days
Description -
PRALUENT
REPATHA

*If the answer to this question is yes, go to question 7.*
*If the answer to this question is no, go to question 8.*

7. Has the patient shown clinical response (significant lowering of LDL-C*) since initiation of PCSK9 inhibitor therapy? Y N

*Significant 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.

*If the answer to this question is yes, go to question 10.*
*If the answer to this question is no, denied*

8. Does the patient 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? Y N

**High Dose Statin Therapy and Ezetimibe Therapy**
Required quantity: 90 days
Look back timeframe: 730 days
-Description
ATORVASTATIN 40MG TABLET
ATORVASTATIN 80MG TABLET
CRESTOR 20MG TABLET
CRESTOR 40MG TABLET
EZALLOR SPRINKLE 20MG CAPSULE
EZALLOR SPRINKLE 40MG CAPSULE
EZETIMIBE 10MG TABLET
LIPITOR 40MG TABLET
LIPITOR 80MG TABLET
ROSUVASTATIN 20MG TABLET

*If the answer to this question is yes, go to question 9.*

*If the answer to this question is no, denied*

9. Does the patient have a documented LDL-C of greater than 70 mg/dL? Y N
*If the answer to this question is yes, go to question 10.*
*If the answer to this question is no, denied*

10. Is this request for a non-preferred drug? Y N
*If the answer to this question is yes, go to question 11.*
*If the answer to this question is no, approved for 180 days.*

11. Has the patient failed a 30-day treatment trial with at least 1 preferred agent within the last 180 days? Y N
*If the answer to this question is yes, approved for 180 days.*
*If the answer to this question is no, go to question 12.*

12. Is there a documented allergy or contraindication to preferred agents in this class? Y N
*If the answer to this question is yes, approved for 180 days.*
*If the answer to this question is no, go to question 13.*

13. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
*If the answer to this question is yes, approved for 180 days.*
*If the answer to this question is no, denied.*

Comments:

*I affirm that the information given on this form is true and accurate as of this date.*

_____ _____
Prescriber (or Authorized) Signature Date