MISSISSIPPI DIVISION OF MEDICAID

Pharmacy Prior Authorization Form

Mississippi Division of Medicaid
Pharmacy Prior Authorization Unit
550 High St., Suite 1000, Jackson, MS 39201

FAX TO: 1-877-537-0720

For Information Call:
1-877-537-0722

Beneficiary ID: | | | | | | | | | | |

Beneficiary Full Name:_____ **DOB:**_____

Prescriber's NPI: | | | | | | | | | | |

Prescriber's Full Name:_____ **Phone:**_____

Prescriber's Address: _____ **FAX:**_____

Pharmacy NPI: | | | | | | | | | | |

Pharmacy Name:_____ **Phone:**_____

Pharmacy Phone: _____ **Pharmacy FAX:** _____

CLINICAL INFORMATION

Requested PA Start Date:_____ **Requested PA End Date:**_____

Drug/Product Requested:_____ **Strength:**_____ **Quantity:**_____

Days Supply:_____ **RX Refills:**_____ **Diagnosis or ICD-10 Code(s):**_____

☐ **Hospital Discharge** ☐ **Additional Medical Justification Attached**

Medications received through coupons and/or samples are not acceptable as justification

MUST SUBMIT THIS PAGE ALONG WITH SPECIFIC PAGE TWO BELOW:

☐	**Brand Name Multi-source** (Must include MedWatch page and Brand Name Multi-source Page 2 from instructions)
☐	**Early Refill** (Must include Early Refill Page 2 from instructions)
☐	**Enteral Nutrition** (Must include Enteral Nutrition Page 2 from instructions)
☐	**Max Unit Override** (Must include Maximum Unit Override Page 2 from instructions)
☐	**Medical Necessity Prior Authorization Form for EPSDT**-eligible beneficiaries (Must include Children's Page 2 from instructions)
☐	**Preferred Drug List Exception Request** (Must include Preferred Drug List Exception Page 2 from instructions)
☐	**Hepatitis C Treatment: Genotypes 1 - 6**
☐	**Respiratory Syncytial Virus (RSV)** - Synagis® (palivizumab) See Synagis® manual authorization criteria.
☐	**Heterozygous Familial Hypercholesterolemia(HeFH) with ASCVD**- REPATHA™ (evolocumab) and PRALUENT®(alirocumab)
☐	**Heterozygous Familial Hypercholesterolemia (HeFH)**- REPATHA™(evolocumab) and PRALUENT®(alirocumab)
☐	**Homozygous Familial Hypercholesterolemia (HoFH)**- REPATHA™ (evolocumab)
☐	*Appeal is no longer a valid form. See instructions for more information.*

Prescribing provider's signature (signature and date stamps, or the signature of anyone other than the provider, are not acceptable)

I certify that all information provided is accurate and appropriately documented in the patient's medical chart.

Signature required: _____ **Date:** _____

Printed Name of Prescribing Provider:_____

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As of January 1, 2014 and in order for DOM to be in compliance with state law, submissions on forms used previously can no longer be accepted for Medicaid beneficiaries and will be returned to the prescriber.

Prior Authorization Determination: If the Pharmacy PA unit approves the prior authorization, the beneficiary can return to the pharmacy to obtain the prescription. The drug claim will pay and no further action will be required.

If the Pharmacy PA unit denies the request, the prescriber's office will be notified immediately. The prescriber has the option of prescribing a different treatment course that does not require prior authorization or submitting a "Reconsideration" form.

REMINDER: *Before submitting a PA request, check for options not requiring PA on the current PDL found at* http://www.medicaid.ms.gov/providers/pharmacy/preferred-drug-list/

Medicaid providers are encouraged to use equally efficacious and cost saving ***preferred*** *agents whenever possible.*

NOTICE: Please see instructions for successfully completing a Prior Authorization Form

Prior Authorization Page 1 along with ONE of the pages below must be completed and faxed in for prior authorization determination.

	Drug Specific Information:	Page
	Brand Name Multi Source (Must include MedWatch page and Brand Name Multi Source Page 2 from instructions)	**2.A**
	Early Refill (Must include Early Refill Page 2 from instructions)	**2.B**
	Enteral Nutrition (Must include Enteral Nutrition Page 2 from instructions)	**2.C**
	Maximum Unit Override (Must include Maximum Unit Override Page 2 from instructions)	**2.D**
	Medical Necessity Prior Authorization Form for EPSDT-eligible beneficiaries (Must include Children's Page 2 from instructions)	**2.E**
	Preferred Drug List Exception Request (Must include Preferred Drug List Exception Page 2 from instructions)	**2.F**
	Hepatitis C Treatment: Genotypes 1 - 6	**2.G**
	Respiratory Syncytial Virus (RSV) - Synagis® (palivizumab) See Synagis® manual authorization criteria.	**2.H**
	Heterozygous Familial Hypercholesterolemia (HeFH) with ASCVD- REPATHA™(evolocumab) and PRALUENT®(alirocumab)	**2.I**
	Heterozygous Familial Hypercholesterolemia (HeFH)- REPATHA™(evolocumab) and PRALUENT®(alirocumab)	**2.J**
	Homozygous Familial Hypercholesterolemia (HoFH)- REPATHA™(evolocumab)	**2.K**
	Appeal is no longer a valid form. See instructions for more information.	

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Beneficiary ID: | | | | | | | | | | Beneficiary Full Name:_____

Brand-Name Multi-Source Drug / Dispense As Written (DAW)* Request — Form 2.A

PRIOR AUTHORIZATION REQUEST FORM

**MS Division of Medicaid requires that all information requested on this form be completed for consideration of approval*

The following brand name drugs are excluded from this requirement:

- ***DOM designated narrow therapeutic index drugs or NTI are Coumadin, Dilantin, Lanoxin, Synthroid, and Tegretol.***
- ***Preferred branded drugs on DOM's PDL.***

The completed FDA MedWatch form must be included with this request. *A copy of the FDA MedWatch form may be obtained online at:* http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf

DOCUMENTATION OF TRIAL OF GENERIC PRODUCT

Generic Product:_____ **Manufacturer:**_____ **Length of Therapy:**_____

Observed adverse reaction or allergic reaction:_____

_____

_____

Documentation Included: ☐ **Yes** ☐ **No**

Generic Product:_____ **Manufacturer:**_____ **Length of Therapy:**_____

Observed adverse reaction or allergic reaction:_____

_____

_____

Documentation Included: ☐ **Yes** ☐ **No**

Has a completed FDA MedWatch form been submitted to the FDA? ☐ **Yes** ☐ **No**

Printed Name of Prescribing Provider:_____ **Date:**_____

FORM 2.A

MISSISSIPPI DIVISION OF MEDICAID

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Early Refill Pharmacy Prior Authorization Request* Form 2.B

MS Division of Medicaid requires that all information requested on this form be completed for consideration of approval.

- No early refill can be authorized if the beneficiary's monthly service limit has been reached.
- MS Medicaid does not generally reimburse for replacement of prescriptions that are lost, stolen or otherwise destroyed.
- MS Medicaid does not pay for vacation supplies.
- Current policy requires at least:
  a) 75% of a non-controlled substance prescription claim's days supply to transpire to pay or a PA request to be approved; or
  b) 85 % of a controlled substance prescription claim's days supply to transpire to pay or a PA request to be approved.

Reason for Request:

☐Prescriber increased the dosing frequency
☐Prescriber increased the number of units per dose
☐New admission to a nursing home
☐Extra medication needed to stop or mitigate further morbidity due to acute clinical condition
Explanation:_____
☐Lost or Stolen: Documentation required**
☐Destroyed (fire, natural disaster, such as flood, tornado, hurricane): Documentation required**
☐Other, specify: _____

Additional Comments:_____

_____

_____

_____

Printed Name of Prescribing Provider:_____ **Date:**_____

* The pharmacist should maintain documentation for each early refill override that is obtained from DOM.
** Documentation must be provided for prescriptions for controlled substances and/or medication with a potential for abuse or resale. Examples of documentation include a police report, insurance report, etc.
Supporting documentation must be available in the patient record.

FORM 2.B

MISSISSIPPI DIVISION OF MEDICAID

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FAX TO: 1-877-537-0720

For Information Call:
1-877-537-0722

Beneficiary ID: | | | | | | | | | | Beneficiary Full Name:_____

Enteral Nutrition Pharmacy Prior Authorization Request — Form 2.C

A copy of the original prescription or order must accompany this PA request.

- Enteral nutritional replacement products are included in the facilities' per diem rate for residents in a long-term care facility (defined as nursing home, intermediate care facility for individuals with intellectual disabilities [ICF/IID] or psychiatric residential treatment facility [PRTF]). Enteral products *ARE NOT REIMBURSABLE* separately as a pharmacy "point of sale" service.
- If the beneficiary is Medicare eligible, then Medicare Part B or Medicare Advantage must be billed first as primary coverage.

Enteral Nutrition may be approved for beneficiaries meeting specified criteria:

- Does the beneficiary have an inborn error of metabolism? YES ☐ NO ☐
- If non-EPSDT eligible, is enteral product requested the sole source of nutrition? YES ☐ NO ☐
- If EPSDT eligible, is enteral product requested sole source or primary (>50%) source of nutritional needs? YES ☐ NO ☐
- Is beneficiary eligible and registered with WIC? YES ☐ NO ☐
  EPSDT eligible beneficiaries up to age 5 years must be registered with the federal program for women, infants, and children (WIC) in order to receive WIC monthly enteral products.

Enteral/Clinical Information:

Enteral Product Name and Strength: _____ NDC Number*: _____
**Note: NDC Numbers are needed for processing and can be obtained by contacting enteral product pharmacy providers.*

Quantity:_____ per ☐ Month OR ☐ Day

- **Age <5 years, and WIC eligible, please indicate:**
  - If WIC eligible, DOM *MAY* allow up to a 30 day transition period for NEW starts on WIC covered products.
  - *Initial* Coverage *until* WIC Benefits start or a *GAP* in coverage of WIC benefits (up to, but not more than, a 30-day supply): _____ -day supply
    - *Please attach and FAX a copy of the WIC program formula request form when submitting this PA form.*
  - WIC Monthly Quantity Limit:_____
    - **Average monthly amount needed after WIC benefits are exhausted:**_____

OR

- **Inborn Errors of Metabolism:** ☐ Yes Diagnosis/ICD-10 code(s):_____ ☐ No

OR

- **Sole Source of Nutrition (solid food not an option-tube feeding) OR special circumstances such as chemotherapy and/or radiation therapy to the head and neck region, etc.):** ☐ Yes Diagnosis/ICD-10 code(s):_____ ☐ No

OR

- **Primary (>50%) or sole source of nutritional needs if EPSDT eligible:** ☐ Yes Diagnosis/ICD-10 code(s):_____ ☐ No

Medical Justification:

_____

Printed Name of Prescribing Provider:_____ **Date:**_____

Approval may be granted for up to 12 months. A prior authorization for enteral nutrition is for the nutritional product only and does not include supplies necessary to administer the nutrient.

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Beneficiary ID: | | | | | | | | | | Beneficiary Full Name:_____

Maximum Unit Override Pharmacy Prior Authorization Request — Form 2.D

- In accordance with state law, Medicaid provides up to a 31-day supply of medications.
- The maximum daily dose is determined according to the FDA-approved and manufacturer's suggested recommended daily dose.
- Some drugs have assigned monthly quantity limits, as recommended by DOM's Drug Utilization Review Board, and are subject to the Maximum Unit Override. The specific agents with the corresponding quantity limits can be found at https://medicaid.ms.gov/providers/pharmacy/pharmacy-resources/ .
- Medicaid may request chart documentation for verification of submitted information.

Criteria for Maximum Unit Override: The request for doses higher than the maximum quantity allowed by Medicaid must be submitted for prior approval:

- The request must be substantiated by diagnosis and supporting medical justification.
- Supporting documentation must be available in the patient record.
- Medication will not be approved for non-FDA approved indications.

1. Specific diagnosis and ICD-10 code(s):

   _____

2. If dosing is weight-based or body surface area-based:

   Beneficiary's Weight: _____ Beneficiary's Height: _____

3. Detailed description of reason beneficiary needs a greater quantity allowed than quantity limit or dose greater than what the FDA approved label recommends:

_____

_____

_____

Printed Name of Prescribing Provider:_____ **Date:**_____

FORM 2.D

MISSISSIPPI DIVISION OF MEDICAID

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Pharmacy Prior Authorization Unit
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FAX TO: 1-877-537-0720

For Information Call:
1-877-537-0722

Beneficiary ID: | | | | | | | | | | | Beneficiary Full Name:_____

Medical Necessity for EPSDT-eligible beneficiaries Prior Authorization Request — Form 2.E

The Division of Medicaid has established a program of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), which provides preventive and comprehensive health services for Medicaid-eligible children and youth up to age twenty-one (21). The service ends on the last day of the beneficiary's twenty-first (21st) birthday month. See MS Administrative Code, Title 23, Part 223.

Reasons for prior authorization request may include, but are not limited to:

- ☐ Request for more than 5 prescription claims per month
- ☐ Request for more than 2 non-preferred/brand name prescription claims per month
- ☐ Request for age-waiver with provider attestation (see age-waiver at bottom of form)
- ☐ Request for non-covered medication (drug not federally rebated)
- ☐ Other: example, drug closed to pharmacy coverage and covered as a medical claim

Notice: *Before submitting a PA request, check for options not requiring PA on the current PDL found at https://medicaid.ms.gov/providers/pharmacy/ . Medicaid providers are encouraged to use equally efficacious and cost saving preferred agents whenever possible.*

Requested Medication (Include strength and dosage formulation)	Diagnosis	ICD-10 Codes	Preferred Product (Yes/No)	Requested Quantity Per Month
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

Medical Necessity: _____

_____

Age Waiver *(if applicable):* I am aware that this drug is not FDA approved for use due to the beneficiary's age. However, I attest that the medical necessity outweighs the risk for this/these medication(s).

Printed Name of Prescribing Provider:_____ Date:_____

FORM 2.E

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For Information Call:
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Beneficiary ID: | | | | | | | | | | Beneficiary Full Name:_____

Preferred Drug List Exception Pharmacy Prior Authorization Request — Form 2.F

Notice: Before submitting a PA request, check for options not requiring PA on the current PDL found at https://medicaid.ms.gov/providers/pharmacy/ . Medicaid providers are encouraged to use equally efficacious and cost-saving preferred agents whenever possible.

Prior drugs used must be reflected in paid pharmacy claims.

1. Has the patient experienced treatment failure with the preferred products(s)? ..... ☐ YES ☐ NO

1st Drug: _____ Length of Therapy:_____

Reason for D/C:_____

2nd Drug: _____ Length of Therapy:_____

Reason for D/C:_____

Attach additional documentation of other treatment failures with preferred drugs if necessary. If no previous preferred drug usage, then additional medical justification must be provided.

2. Does the patient have a condition that prevents the use of the preferred products(s)?..... ☐ YES ☐ NO

If YES, list the condition/issue(s): _____

_____

3. Is there a potential drug interaction between another medication and the preferred products(s)?..... ☐ YES ☐ NO

If YES, list the interaction(s):_____

_____

4. Has the patient experienced intolerable side effects while on the preferred product(s)? ..... ☐ YES ☐ NO

If YES, list the side effects(s):_____

_____

Printed Name of Prescribing Provider:_____ Date:_____

*MS Division of Medicaid requires that all information requested on this form be completed for consideration of approval.

FORM 2.F

MISSISSIPPI DIVISION OF MEDICAID

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Hepatitis C Therapy PA Request

Form 2.G

Diagnosis / Treatment Status ***(check all that apply)*** ***See Hepatitis-C PA instruction sheet below for approval criteria and intolerance definitions.**

□ Prescriber is, or has consulted with a gastroenterologist, hepatologist, ID specialist or other Hepatic specialist. Requires consult within the past year with documentation of recommended regimen.

□ Active HCV infection verified by viral load within the last year: HCV RNA: _____ million IU/mL Date:_____

Genotype verified by lab: □ 1a □ 1b □ 2 □ 3 □ 4 □ 5 □ 6

Patient is:
- □ Treatment naïve □ Relapser
- □ Prior partial responder □ Prior null responder
- □ Stopped prior therapy for other reason: _____

HIV status: □ positive □ negative □ unknown

□ Patient has not taken amiodarone within 535 days (required if regimen includes Harvoni or Sovaldi)

□ RBV-Ineligible* *Ineligibility reason: _____

Hepatic fibrosis stage ___ Last stage evaluation date: _____Method of cirrhosis/fibrosis stage:_____

□ Decompensated cirrhosis
□ Compensated cirrhosis Child-Pugh Score: _____
□ Post-liver transplant
□ Hepatocellular carcinoma and awaiting a liver transplant: Transplant date: _____
□ Not yet scheduled
□ Dialysis __Yes/____No
□ CrCl ____ mL/min Lab Date w/n last year:_____

□ Screened for HEP-B and HIV prior to HEP-C tx start
Repeat screening should be patient specific.
Tx considered per AASLD/IDSA guidelines.

Prior HCV Treatment: last two regimens, if any
Regimen: _____ Dates/duration of use: _____ Response: _____
Regimen: _____ Dates/duration of use: _____ Response: _____

Social History ***(check all that apply)***

□ Patient is 18 years old or older

Documentation (available if requested) of:

□ Counseling regarding abstinence from alcohol, IV drug use and education on how to prevent HCV transmission.
□ Abstinence from drugs and alcohol for at least 6 months; negative urine drug screen required if there is IV drug use history.

For women of childbearing potential and male patients with female partners of childbearing potential *(for RBV regimens only)*:

□ Patient is not pregnant (or a male with a pregnant female partner) and not planning to become pregnant during treatment or within 6 months of stopping treatment.
□ Agreement that partners will use two forms of effective contraception during treatment and for at least 6 months after stopping treatment.
□ Verification that monthly pregnancy tests will be performed throughout treatment.

Regimen Requested* ***See Hepatitis-C PA instruction sheet below for drug regimens and intolerance definitions.**

Regimens using preferred drugs:

□ Harvoni	for _____ weeks	□ Viekira Pak® + RBV or Viekira XR + RBV	for _____weeks
□ Harvoni + RBV	for _____ weeks	□ Viekira Pak or Viekira XR	for _____weeks
□ Sovaldi + RBV	for _____ weeks	□ Technivie + RBV	for _____ weeks
□ Epclusa	for _____ weeks	□ Zepatier	for _____ weeks
□ Epclusa + RBV	for _____ weeks	□ Zepatier + RBV	for _____ weeks

□ OTHER drugs/treatment duration: _____

Please provide clinical rationale for choosing a regimen beyond current guidelines guidance, or for selecting regimens using non-preferred drugs.

Prescription Information

Drug name / strength	Frequency / instructions	Quantity	Refills

FORM 2.G

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Beneficiary ID: | | | | | | | | | | Beneficiary Full Name:_____

RSV-Synagis Prior Authorization Form* Form 2.H

PA requests will be accepted starting October 10, 2016 for dates of service starting November 1, 2016.
Synagis® will not be authorized for administration prior to November 1, 2016. PA requests will be approved starting at the onset of RSV season for a maximum of up to 5 doses and a dosing interval *not less than 30 days* between injections.
Synagis® dosing authorizations will extend for the recommended number of doses *OR* until the end of epidemic RSV season as defined by CDC - *whichever occurs first*. DOM will notify providers when the end of the RSV season is determined.
Monthly prophylaxis should be discontinued for any infant or young child who experiences a breakthrough RSV hospitalization.

PA REQUEST INFORMATION:

PHARMACY INFORMATION – Synagis® is available through a limited distribution network established by the manufacturer. The following list includes previously approved pharmacy providers. If the requesting pharmacy provider is not included in this list, select "Other" and provide pharmacy information including name, address, telephone number, Medicaid provider number, etc.

☐ Acro Pharmaceutical Services ☐ AcariaHealth ☐ BriovaRx ☐ NMMC ☐ UMC ☐ Vital Care

☐ Other NPI: _____ PH: _____ FAX: _____

Birth Date: _____ Gestational Age: _____ wks: _____ days: ____ Birth Weight: _____lbs. ____oz.

NDC#: _____ Current Weight: _____lbs. ____oz. Date last weighed: _____

Did the patient receive Synagis in the hospital? Yes ____ No ____ If "Yes", list date(s) of administration: _____

Check the criteria used to qualify the patient for Synagis®. All information requested on PA form must be completed for approval consideration.

Age ≤ 1 year at start of RSV season and one of the following:

◯ Prematurity of ≤ 28 weeks 6 days gestation.

◯ Documentation of **chronic lung disease** (CLD) of prematurity*.

◯ Documentation of **hemodynamically significant CHD AND** one of the following:
(1) **Acyanotic heart disease** receiving medication for congestive heart failure **AND** will require cardiac surgery.
(2) **Moderate to severe pulmonary** hypertension.
(3) Documentation of **cyanotic heart disease** through consultation with pediatric cardiologist.

◯ Documentation of **congenital abnormalities of the airway OR neuromuscular disease** that impairs the ability to clear secretions from the upper airway because of ineffective cough.

◯ Documentation of **cystic fibrosis AND** clinical evidence of CLD of prematurity* **OR** nutritional compromise.

Documentation of being **profoundly immunocompromised**** during the RSV season.

Age 12 – 24 months at start of RSV season and one of the following:

◯ Documentation of **chronic lung disease** (CLD) of prematurity* **AND** required continued medical support** during the 6-month period before the RSV season.

◯ Documentation of **cystic fibrosis AND** one of the following:
(1) Manifestations of **severe lung disease****.
(2) Weight for length < 10th percentile.

Documentation of being **profoundly immunocompromised**** during the RSV season.

**** Chronic lung disease of prematurity defined as gestational age ≤ 31 weeks 6 days AND requirement for oxygen >21% or chronic ventilator therapy for at least the first 28 days after birth. ** Refer to 2016-17 Division of Medicaid Synagis® PA Criteria Instructions for more detailed definitions. Reference: Pediatrics 2014:134; 415 originally published online July 28, 2014.***

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Heterozygous Familial Hypercholesterolemia (HeFH) with ASCVD: Prior Authorization Request Form 2.I

REPATHA™ (EVOLOCUMAB) and PRALUENT® (ALIROCUMAB)

Initial Approval Criteria for Repatha™ (evolocumab) or Praluent® (alirocumab) may be approved when the following criteria are met:

☐ Yes ☐ No	The member is ≥ 18 years of age.
AND	
☐ Yes ☐ No	Repatha™ (evolocumab) or Praluent® (alirocumab) must be prescribed by or in consultation with a cardiologist, endocrinologist or lipid specialist and there is clinical documentation for a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD), defined as one of the following: acute coronary syndrome, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack, or peripheral arterial disease presumed to be of atherosclerotic origin.
AND	
☐ Yes ☐ No	Unable to meet LDL-C goal after treatment of at least 2 sequential 12-week trials of different high intensity statins [(i.e., atorvastatin ≥40mg or rosuvastatin ≥ Fc20mg] with at least one concomitant 12-week use of Zetia (ezetimibe) 10mg UNLESS contraindicated or not tolerated. (See Appendices A and C). Suboptimal response is defined as where: • LDL-C is known: <50% reduction in LDL-C from pre-treatment levels
AND	
☐ Yes ☐ No	The member will be using the PCSK9 inhibitor concomitantly with a maximally-tolerated statin unless statin intolerant (See Appendices). In ASCVD patients with/without comorbidities*, who are on maximally tolerated statin-ezetimibe or non-statin combination therapy in the setting of documented statin intolerance, who achieve a less-than-anticipated response with <50% reduction in LDL-C, it is reasonable to prescribe alirocumab or evolocumab (in addition to or in place of ezetimibe) as second step to achieve further LDL-C reduction. *Comorbidities defined as: diabetes, recent (<3 month) ASCVD event, ASCVD event while already on statin, poorly controlled risk factors, elevated lipoprotein or chronic kidney disease not on hemodialysis. If a PCSK9 inhibitor is prescribed, clinicians should continue maximally tolerated statin and monitoring for adherence to medications and lifestyle, side effects, and ongoing LDL-C response to therapy. Adherence to current statin regimen must be evidenced by consistent pharmacy claims over the past 12 weeks, unless new to Medicaid.

Recommended Dosing Regimen and Authorization Limit

Drug	Dosing Regimen
Praluent®	150 mg SC Q 2 weeks
Repatha™	140mg SC Q 2 weeks

Reauthorization Criteria:

☐ Yes ☐ No	Criteria outlined for initial Prior Authorization has been satisfied;
AND	
☐ Yes ☐ No	Is there clinical evidence of ongoing concomitant lipid lowering therapy (statin, ezetimibe, unless contraindicated / not tolerated);
AND	
☐ Yes ☐ No	Documentation of a LDL-C reduction from pretreatment level by ≥ 50% after adding Repatha (evolocumab) or by ≥ 40% after adding Praluent® (alirocumab) for at least 90 days of therapy.

Authorization

Initial: If approved, initial coverage will be granted for up to 12 weeks.

Maintenance: If approved, maintenance coverage will be reauthorized for periods of up to 52 weeks.

APPENDICES AND TABLES CAN BE FOUND IN THE INSTRUCTION SHEET

FORM 2.I

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Beneficiary ID: | | | | | | | | | | Beneficiary Full Name:_____

Heterozygous Familial Hypercholesterolemia (HeFH): Pharmacy Prior Authorization Request Form 2.J

REPATHA™ (EVOLOCUMAB) and PRALUENT® (ALIROCUMAB)

Initial Approval Criteria for Repatha™ (evolocumab) or Praluent® (alirocumab) may be approved when the following criteria are met:

☐ Yes ☐ No	The member is ≥ 18 years of age.
AND	
☐ Yes ☐ No	Repatha™ (evolocumab) or Praluent® (alirocumab) must be prescribed by or in consultation with a cardiologist, endocrinologist or lipid specialist and there is clinical documentation of one of the following: a.) Presence of a mutation in the LDLR, ApoB, PCSK9 or ARH adaptor protein (LDLRAP1) gene; **OR** b.) Physical signs of FH, such as presence of tendon xanthomas, corneal arcus in a member < 45 years of age, tuberous xanthomas, or xanthelasma; **OR** c.) Clinical diagnosis based on the World Health Organization (WHO)/Dutch Lipid Clinical Network criteria with a "probable familial hypercholesterolemia" score of ≥ 6 points (see Table 2)
AND	
☐ Yes ☐ No	Unable to meet LDL-C goal after treatment of at least 2 sequential 12-week trials of different high intensity statins [(i.e., atorvastatin ≥40mg or rosuvastatin ≥20mg] with at least one concomitant 12-week use of Zetia (ezetimibe) 10mg UNLESS contraindicated or not tolerated. Adherence to the current statin regimen must be evidenced by consistent pharmacy claims over the past 12 weeks, unless new to Medicaid.
AND	
☐ Yes ☐ No	Use of the PCSK9 inhibitor will be concomitant with a maximally-tolerated statin, and ezetimibe (Zetia) unless contraindicated/intolerant. (See Appendices A and C)

Recommended Dosing Regimen and Authorization Limit

Drug	Dosing Regimen
Praluent®	150 mg SC Q 2 weeks
Repatha™	140mg SC Q 2 weeks

Reauthorization Criteria:

☐ Yes ☐ No	Criteria outlined for initial Prior Authorization has been satisfied;
AND	
☐ Yes ☐ No	Is there clinical evidence of ongoing concomitant lipid lowering therapy (statin, ezetimibe, unless contraindicated / not tolerated);
AND	
☐ Yes ☐ No	Documentation of a LDL-C reduction from pretreatment level by ≥ 50% after adding Repatha (evolocumab) or by ≥ 40% after adding Praluent (alirocumab) for at least 90 days of therapy.

Authorization

Initial: If approved, initial coverage will be granted for up to 12 weeks.

Maintenance: If approved, maintenance coverage will be reauthorized for periods of up to 52 weeks.

APPENDICES AND TABLES CAN BE FOUND IN THE INSTRUCTION SHEET

FORM 2.J

MISSISSIPPI DIVISION OF MEDICAID

Pharmacy Prior Authorization Form
Mississippi Division of Medicaid
Pharmacy Prior Authorization Unit
550 High St., Suite 1000, Jackson, MS 39201

FAX TO: 1-877-537-0720
For Information Call:
1-877-537-0722

Beneficiary ID: | | | | | | | | | | Beneficiary Full Name:_____

Homozygous Familial Hypercholesterolemia (HoFH): Pharmacy Prior Authorization Request Form 2.K

REPATHA™ (EVOLOCUMAB)

Initial Approval Criteria for Repatha™ (evolocumab) may be approved when the following criteria are met:

☐ Yes ☐ No	The member is ≥ 13 years of age.
AND	
☐ Yes ☐ No	Evolocumab (Repatha) must be prescribed by or in consultation with a cardiologist, endocrinologist or lipid specialist and there is clinical documentation of one of the following: a.) Genetic confirmation of two mutant alleles at the LDLR, ApoB, PCSK9, or LDLRAP1 gene locus **OR** b.) Treated LDL-C of > 300 mg/dL or non-HDL-C 330 mg/dL or untreated LDL-C of > 500 mg/dL with either: i.) Cutaneous and/or tendon xanthoma before age 10 years **OR** ii.) Untreated LDL-C levels consistent with heterozygous familial hypercholesterolemia in both parents (> than 190 mg/dL);
AND	
☐ Yes ☐ No	Unable to meet LDL-C goal after treatment of at least 2 sequential 12-week trials of different high intensity statins [(i.e., atorvastatin ≥40mg or rosuvastatin ≥20mg] with at least one concomitant 12-week use of Zetia (ezetimibe) 10mg UNLESS contraindicated or not tolerated. (see Table 1 for dosages for therapy intensity; Appendix A for statin contraindications; Appendix B for Zetia contraindications) Adherence to the current statin regimen and Zetia (ezetimibe) must be evidenced by consistent pharmacy claims over the past 12 weeks, unless new to Medicaid. • If unable to tolerate a high-intensity statin, concomitant use with Zetia (ezetimibe) of a moderate to low-intensity statin at maximally tolerated dose can be used (see Appendix C).
AND	
☐ Yes ☐ No	Repatha™ (evolocumab) will be used concomitantly with the statin and Zetia (ezetimibe), unless intolerance/contraindication justification is submitted (see Appendices A, B and C).
☐ Yes ☐ No	Repatha™ (evolocumab) is not being used concomitantly with Juxtapid® (lomitapide), Kynamro® (mipomersen), or another PCSK9 inhibitor.

Recommended Dosing Regimen and Authorization Limit

Drug	Dosing Regimen
Repatha™(evolocumab)	420mg SC once monthly

Reauthorization Criteria:

☐ Yes ☐ No	Documentation of a LDL-C reduction from pretreatment level by ≥ 20% after adding Repatha™ for at least 90 days of therapy.
AND	
☐ Yes ☐ No	Is there clinical evidence of ongoing concomitant lipid lowering therapy (statin, ezetimibe, LDL-apheresis unless contraindicated/not tolerated)?

Authorization

Initial: If approved, initial coverage will be granted for up to 12 weeks.

Maintenance: If approved, maintenance coverage will be reauthorized for periods of up to 52 weeks.

APPENDICES AND TABLES CAN BE FOUND IN THE INSTRUCTION SHEET

FORM 2.K