South Dakota Department of Social Services

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Praluent® & Repatha® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Heterozygous familial hypercholesterolemia (HeFH)
- ❑ Homozygous familial hypercholesterolemia (HoFH) [**Repatha** only]
- ❑ Hyperlipidemia in a high risk patient with clinical arteriosclerotic cardiovascular disease (ASCVD)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Is the patient's baseline LDL-C level greater than or equal to 70 mg/dL? ❑ **Yes** ❑ **No**

Has the patient been receiving high dose statin therapy for at least 3 months (i.e., atorvastatin tab 40 mg, atorvastatin tab 80 mg, rosuvastatin tab 20 mg, rosuvastatin tab 40 mg)? ❑ **Yes** ❑ **No**

Is the patient a non-candidate for high dose statin therapy (e.g., labeled contraindication to all statins, patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with creatine kinase elevations greater than 10 times upper limit of normal [ULN])? ❑ **Yes** ❑ **No**

Is the requested medication prescribed by or in consultation with a cardiologist or endocrinologist? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following:

Is there documentation of positive clinical response to therapy with LDL level less than 70 mg/dl or decreased 30% from baseline? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.