OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare
Leqvio® (Inclisiran) Prior Authorization Form

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Member Name:_____ ***Date of Birth:***_____ ***Member ID#:***_____

Drug Information

☐**Physician billing (HCPCS code:**_____**)** ☐**Pharmacy billing (NDC:**_____**)**

Dose:_____ ***Regimen:***_____ ***Start Date:***_____

Billing Provider Information

Provider NPI:_____ ***Provider Name:***_____

Provider Phone:_____ ***Provider Fax:***_____

Prescriber Information

Prescriber NPI:_____ ***Prescriber Name:***_____

Prescriber Phone:_____ ***Prescriber Fax:***_____ ***Specialty***:_____

Criteria

For Initial Authorization (Initial approval will be for the duration of 6 months):

1. Please indicate member's diagnosis:
   - ☐ **Heterozygous familial hypercholesterolemia (HeFH)** confirmed by 1 or more of the following:
     - ☐ Documented functional mutation(s) in low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality via genetic testing *(results of genetic testing must be submitted)*
     - ☐ Pre-treatment total cholesterol >290mg/dL or LDL-cholesterol (LDL-C) >190mg/dL
     - ☐ History of tendon xanthomas in either the member, first degree relative, or second degree relative
     - ☐ Dutch Lipid Clinic Network Criteria score of >8
   - ☐ **Established atherosclerotic cardiovascular disease (ASCVD)**. Please provide supporting diagnoses/ conditions and dates of occurrence signifying established ASCVD:
     Diagnosis/condition: _____ Date of occurrence:_____
     Diagnosis/condition: _____ Date of occurrence:_____
   - ☐ **Primary hyperlipidemia**
     - ☐ Untreated LDL-C level ≥190mg/dL
     - ☐ Current LDL-C level ≥100mg/dL
2. Will Leqvio® be used as an adjunct to diet and statin therapy? Yes☐ No☐
3. Has member tried any of the following medications? Check all that apply. Provide trial dates and specific medication if applicable.
   a. ☐ Statin therapy; dates:_____
      i. Medication/strength:_____ Dosing regimen:_____
   b. ☐ Ezetimibe; dates:_____
   c. ☐ Proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor; dates:_____
      ii. Medication/strength:_____ Dosing regimen:_____

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.	

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Criteria

For Initial Authorization: (*continued*)

4. If the member has **not** been on a stable dose of statin therapy for at least 4 weeks, is the member intolerant to statin therapy? Yes☐ No☐
   a. If yes, please indicate 1 of the following:
      ☐ Rhabdomyolysis - creatine kinase (CK) labs verifying this diagnosis must be provided.
      ☐ An FDA labeled contraindication to all statins. Provide contraindication: _____
      ☐ Documented intolerance to at least 2 different statins at lower doses or at intermittent dosing:
      Please provide all of the following:
      1) Medication/strength: _____ Dosing regimen: _____
         Duration of treatment: _____ Reason for discontinuation: _____
      2) Medication/strength: _____ Dosing regimen: _____
         Duration of treatment: _____ Reason for discontinuation: _____
5. Member's baseline LDL-C: _____ Current LDL-C: _____ Goal LDL-C: _____
6. Will Leqvio® be administered by a health care professional? Yes☐ No☐
7. How will Leqvio® will be administered (e.g., prescriber, pharmacist, home health care provider): _____
8. If Leqvio® will be administered in a health care facility, will it be shipped directly to the facility? Yes☐ No☐
9. If Leqvio® will be dispensed to the member for delivery to a health care provider for administration, has the member been counseled on the proper storage of Leqvio®? Yes☐ No☐

For Continued Authorization:

1. Has member been compliant with Leqvio® treatment? Yes☐ No☐
2. Please provide a recent LDL-C level for this member: _____ Date taken: _____

Additional information: _____

_____

_____

Prescriber Signature: _____ **Date:** _____

By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.
Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

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