aetna®

Alirocumab (Praluent™) Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	E-mail:
Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms		Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____	Does patient have other coverage? ☐ Yes ☐ No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured:	Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check one):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ Cardiologist ☐ Primary Care Physician ☐ **Other**:

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Medication: ☐ Praluent 75 mg ☐ Praluent 150 mg **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: ☐ _____ ☐ Other: _____ ** Please attach rationale*

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For All Requests: *(clinical documentation must be submitted for review)*

Please indicate the patient's triglyceride level: _____ Date taken: _____

☐ Yes ☐ No Does the patient have severe renal impairment (eGFR less than 30ml/min)?

☐ Yes ☐ No Does the patient have severe hepatic impairment?

☐ Yes ☐ No ☐ N/A If the patient is female, is the patient pregnant or planning to become pregnant?

☐ Yes ☐ No Has the patient failed therapy with 2 different maximally-tolerated doses* of high potency statins used in combination with ezetimibe?

→ ***If yes:*** ***Please indicate date range of ezetimibe (Zetia®) therapy***: _____

Please indicate regimen 1: Drug Name: _____ Dose: _____ Duration: _____ Start Date: _____

What was the LDL after at least 4 weeks of treatment? LDL: _____ Date taken: _____

☐ Yes ☐ No Was the patient at least 80% compliant with this regimen?

Please indicate regimen 2: Drug Name: _____ Dose: _____ Duration: _____ Start Date: _____

What was the LDL after at least 4 weeks of treatment? LDL: _____ Date taken: _____

☐ Yes ☐ No Was the patient at least 80% compliant with this regimen?

* If maximum statin doses were not used (eg rosuvastatin (Crestor®) 20 mg or higher, atorvastatin (Lipitor®) 40 mg or higher, or simvastatin 40 mg or higher) please indicate the reason for a lower dose: _____

☐ Yes ☐ No Will the patient be taking Praluent in combination with a statin?

☐ Yes ☐ No Has the patient received samples of Praluent*?

**Sampling of Praluent does not guarantee coverage under the provisions of the pharmacy benefit*

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION ***(continued)*** – Required clinical information must be completed in its entirety for all precertification requests.

Please complete the following questions that pertain to the patient's situation: *(clinical documentation must be submitted for review)*

☐ Yes ☐ No Has the patient been diagnosed with **Heterozygous familial hypercholesterolemia (HeFH)**?

If yes:
- ☐ Yes ☐ No Was the cholesterol level higher than 190 mg/dl either pre-treatment or highest on treatment?
- ☐ Yes ☐ No Does the patient have documentation of tendon xanthomas?
- ☐ Yes ☐ No If the answer to the above 2 questions is "no", is there evidence of these signs in a first or second-degree relative?
- ☐ Yes ☐ No Is there clinical documentation of DNA-based evidence of a receptor mutation such as LDL-R, apo-B100 or a PCSK9 mutation?
- ☐ Yes ☐ No Is there clinical documentation of other genetic typing indicating the presence of heterozygous familial hypercholesterolemia?

☐ Yes ☐ No Does the patient have **existing clinical cardiovascular disease**?

If yes:
- ☐ Yes ☐ No Does the patient have existing cardiovascular disease evidenced by a history of AMI, silent MI, unstable angina, coronary revascularization procedure (PCI or CABG)?
- ☐ Yes ☐ No Does the patient have clinically significant atherosclerotic cardiovascular disease diagnosed by invasive or noninvasive testing (such as coronary angiography, stress test using treadmill, stress echocardiography, or nuclear imaging)?

H. ACKNOWLEDGEMENT

Request Completed By ***(Signature Required):*** _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.