Standard Prior Authorization Addendum
PCSK9 Inhibitors

In addition to the Texas Standard Prior Authorization Request Form for Prescription Drug Benefits, please complete the below information. The information below is essential to processing the prior authorization for the selected drug. Incomplete forms or failure to submit this addendum may cause delays in patient care and/or prior authorization denial. **Please fax the completed Standard Prior Authorization Form and Addendum to (866) 469-8590 for fee-for-service Medicaid-eligible individuals.** If the patient is enrolled in managed care, please contact the appropriate health plan for forms and instructions.

For the complete PCSK9 Inhibitors Prior Authorization policy, please see the Fee-For-Service Clinical Prior Authorization Request Form and Policy for PCSK9 Inhibitors.

Section I — Patient Information

Name	**Medicaid ID**	**DOB**

Section II — Prescriber Information

Name:	**NPI#:**	**Phone:**

Section III — Medication Information

1. a. Has the patient tried 90 days of atorvastatin? b. Last prescribed dose: mg Start date: End	Yes	No
2. a. Has the patient tried 90 days of rosuvastatin? b. Last prescribed dose: mg Start date: End	Yes	No
3. a. Has the patient tried 90 days of treatment with ezetimibe concurrently with atorvastatin or rosuvastatin, immediately prior to PSCK9 inhibitor PA request? b. Last prescribed dose: mg Start date: End	Yes	No
4. Is the low density lipoprotein-cholesterol (LDL-C) level >130mg/dl despite treatment with 90 days of atorvastatin treatment, 90 days of rosuvastatin, and most recently, 90 days of ezetimibe treatment?	Yes	No

* For current therapy, indicate "N/A" for "End date".

Section IV — Laboratory Information

1. LDL-C prior to initiation of PCSK9 treatment: mg/dL	Date level obtained:
2. LDL-C: mg/dL* (level must be from previous 60 days)	Date level obtained:

*Required for renewal requests only**.** Must have at least a 50% reduction in LDL-C compared to LDL-C level prior to PCSK-9 treatment initiation for patients with HeFH and at least a 30% reduction in LDL-C for patients with HoFH for renewal approval.

Section IV — Review

☐ Expedited/Urgent Review Requested: By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Signature of prescriber or prescriber's designee Date