Texas Standard Prior Authorization Form - PCSK9 Inhibitors

Please complete and **fax all required documents to Envolve Pharmacy Solutions at 1-833-423-2523** for prior authorization requests for Superior HealthPlan members.

Superior follows the Texas Vendor Drug Program clinical prior authorization criteria for PCSK9 inhibitors.

Section 1 - Patient Information

First Name	**Last Name**	**MI**

DOB	**Cardholder ID**	**Applicable drug allergies**

Section 2 - Patient History

Required Diagnosis (please check one of the following):	
☐ Diagnosis of Heterozygous Familial Hypercholesteremia	Date of diagnosis:
☐ Clinical Atherosclerotic Cardiovascular Disease	Date of diagnosis:
☐ Diagnosis of Homozygous Familial Hypercholesteremia	Date of diagnosis:

Drug Treatment History (complete as applicable):

Drug	**Last prescribed dose**	**Start date**	**End date** (if applicable)
☐ atorvastatin			
☐ ezetimibe			
☐ rosuvastatin			
☐ other (list drug name(s) below)			

Section 3 - PCSK9 Inhibitor Prescription Information

Drug name and strength:	Directions:
Please indicate PSCK9 treatment status	
☐ Initial	☐ Continuation; Date of treatment initiation: _____

Section 4 - Laboratory Information

LDL-C prior to initiation of PCSK9 treatment: _____ mg/dL	Date level obtained: _____ (for first time requests, level must be from previous 60 days)
Current LDL-C: _____ mg/dL*	Date level obtained: _____ (level must be from previous 60 days)

***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 5 - Prescriber Information and Signature

Prescriber Name (Last, First)		**Prescriber NPI**	
Address	**City**	**State**	**ZIP**

Prescriber license	**Specialty (if applicable)**	**Office Phone**
Preparer Name (if other than prescriber)		**Office Fax**

By signing below, I, the prescriber, certify that the information provided above is verifiable and accurate to the best of my knowledge.

Prescriber Signature: **Date:**