South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-22941

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EVKEEZA PRIOR AUTHORIZATION REQUEST FORM

This form **MUST BE** submitted with medical records to support services

Date:		
RECEIPIENT INFORMATION		
Medicaid ID:	**Date of Birth:**	**Sex:** M ☐ F ☐
Last Name:	**First Name:**	
GENERAL INFORMATION		
First Date of Service:	**Last Date of Service:**	
Primary Diagnosis Code:	**HCPC Code:**	
Drug Name:	**Dose & Frequency:**	
Hospitalizations/Treatments/Medications Used in the last 6 months:		
POINT OF CONTACT		
Name and Title:		
Email:	**Phone:**	**Fax:**
Note: *The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA. The determination notice will be sent to the listed point of contact.*		
REFERRING PROVIDER INFORMATION		
Name:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	
SERVICING PROVIDER INFORMATION		
Name:		
Address:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	

CRITERIA	
☐	**Medical records to support use of product are submitted**
Initial Therapy (check one)	**Yes** ☐ **No** ☐
☐	Therapy is prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist
☐	Individual has a diagnosis of HoFH defined as **one** of the following: ☐ Genetic mutation indicating HoFH (e.g., mutations in low density lipoprotein receptor [LDLR] gene, proprotein convertase subtilisin kexin 9 [PCSK9] gene, apolipoprotein B [apo B] gene, low density lipoprotein receptor adaptor protein 1 [LDLRAP1] gene) ☐ Treated LDL-C ≥ 300 mg/dL and one of the following ☐ Tendinous or cutaneous xanthoma prior to age 10 years ☐ Evidence of HeFH in both parents (e.g., documented history of elevated DLC ≥ 190 mg/dL prior to lipid-lowering therapy) ☐ Untreated LDL-C ≥ 500 mg/dL
☐	Individual meets **one** of the following regarding statin therapy ☐ Individual is currently taking high intensity statin therapy (high intensity statin is defined at atorvastatin ≥40mg or rosuvastatin ≥20mg) and has been compliant with therapy for ≥3 months ☐ Individual is statin intolerant based on **one** of the following ☐ Inability to tolerate at least two statins, with at least one started at the lowest daily starting dose ☐ Development of statin associated rhabdomyolysis or immune-mediated necrotizing myopathy (IMNM) after a trial of one statin ☐ Individual has a contraindication to statin therapy including but not limited to active liver disease, unexplained persistent elevation of hepatic transaminases or pregnancy
☐	Individual meets **one** of the following regarding ezetimibe therapy ☐ Individual is currently taking at a dose of 10mg daily and has been compliant with therapy for ≥3 months ☐ Individual has had a trial and inadequate response to ezetimibe therapy ☐ Individual is intolerant of ezetimibe as documented by provider
☐	Individual meets **one** of the following regarding proprotein convertase subtilisin kexin type 9 (PCSK9) inhibitor therapy ☐ Individual is currently taking PCSK9 therapy with evolocumab (Repatha) or alirocumab (Praluent) at FDA approved doses and has been compliant with therapy for ≥3 months. ☐ Individual has had a trial and inadequate response to PCSK9 therapy as indicated by LDL reduction of ≤50% from baseline ☐ Individual is intolerant of PCSK9 therapy ☐ Documentation is provided that individual is LDLR negative
☐	Therapy will not be used concomitantly with lomitapide (Juxtapid)
☐	Individual is ≥1 year of age

Continuation of Therapy (check one)	**Yes** ☐	**No** ☐
☐	Individual continues to meet initial criteria	
☐	Individual continues to use in combination with other lipid lowering therapies including maximum tolerated statin, ezetimibe and PCSK9 inhibitor therapy (unless previously waived due to contraindication or intolerance)	
☐	Documentation is provided individual has had a reduction in total LDL-C since starting Evkeeza therapy	
PHYSICIAN SIGNATURE – PROVIDER ONLY		
This form must be signed by a provider		
☐	I certify that the information given in this form is a true and accurate medical indication for the required product	
Name & Title (Printed):		**Specialty:**
Signature:		