

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: Medicare Part B Medicare Part D
 This request is: Expedited request Standard request

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

KynamroTM (mipomersen)

Member

Last Name: _____ First Name: _____
 ID #: _____ DOB: _____ Gender: _____
 Primary Care Physician: _____
 Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____
 Provider Address: _____
 Provider NPI: _____ Contact Name: _____
 Provider Signature: _____ Date: _____

Drug information

New request Continuation request
 Kynamro 200 mg/mL subcutaneous **Start date** (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

1. Must be used for a medically-accepted indication*
2. Must be prescribed by a cardiologist, lipidologist, endocrinologist, and/or geneticist
3. Must try one of the following drugs:
 - atorvastatin
 - rosuvastatin (Crestor)
 - cholestyramine
 - niacin ER

Medically accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — or — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

Priority Health Precertification Documentation

A. What is the patient's diagnosis?

- Homozygous familial hypercholesterolemia (HoFH)
- Heterozygous familial hypercholesterolemia (HeFH)
- Hypercholesterolemia, uncontrolled with maximally tolerated lipid-lowering therapy
- Other – the patient's condition is: _____

B. What is the prescriber's specialty?

- Cardiologist
- Lipidologist
- Endocrinologist
- Geneticist

C. Which of the following has the patient tried?

- atorvastatin Dates of use: _____
- rosuvastatin (Crestor) Dates of use: _____
- cholestyramine Dates of use: _____
- niacin ER Dates of use: _____
- None of the above **Rationale for use:** _____

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? Yes No

If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Kynamro likely be the most effective option for this patient?

- No
- Yes, because: _____

If the patient is currently using Kynamro, would changing the patient's current regimen likely result in adverse effects for the patient?

- No
- Yes, because: _____