Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Praluent
(alirocumab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Notice: Please be sure to complete this form in its entirety.
Missing information makes it difficult to approve requests and creates a longer processing time.

Medication Requested: ☐ Praluent 75mg ☐ Praluent 150mg ICD10:

Directions for use and Quantity: Duration of therapy:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

What is your patient's diagnosis?
☐ hyperlipidemia WITH atherosclerotic cardiovascular disease (ASCVD)
☐ primary hyperlipidemia [including heterozygous familial hypercholesterolemia (HeFH)]
☐ hyperlipidemia withOUT either ASCVD or FH
☐ other *(please specify):*

Clinical Information
Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples of Praluent, please choose "new start of therapy".
☐ new start
☐ continuation of therapy AND patient is NEW to Praluent or NEW to Cigna (please answer ALL questions below)
☐ continuation of therapy AND patient has previous approval/authorization by Cigna (please answer **questions only)

**(if continued therapy) Does your patient have documented evidence of clinical beneficial response (for example, demonstrated reduction of LDL-C)? Yes ☐ No ☐

**(if no) Please provide clinical support for the continued use of Praluent.

Cigna's preferred product is Repatha.
Has your patient tried Repatha in the past? Yes ☐ No ☐
(if yes) What was the documented response to Repatha? **Supportive documentation must be included**
(if no) Is your patient a candidate for Repatha? Yes ☐ No ☐

If not a candidate, please explain. **Supportive documentation must be included**

While taking Praluent, will your patient also be treated with diet AND maximally tolerated statin therapy?
☐ No, only diet (patient IS a candidate for statin therapy)
☐ No, only diet (patient is NOT a candidate for statin therapy due to a contraindication or previous intolerance)
☐ No, only maximally tolerated statin therapy
☐ Yes, both diet AND maximally tolerated statin therapy
☐ none of the above
**(if no/none) Please provide clinical support for your patient NOT using both diet and maximally tolerated statin therapy.

(if hyperlipidemia with ASCVD) Is there documentation that your patient has one of the following diagnoses?
☐ coronary heart disease (acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization)
☐ cerebrovascular disease (stroke/transient ischemic attack)
☐ peripheral arterial disease (PAD) of atherosclerotic origin
☐ none of the above

(if primary hyperlipidemia) Is there documentation that one of the following was used to confirm a diagnosis of HeFH in your patient?
☐ clinical manifestations of HeFH (for example, cutaneous xanthomas, tendon xanthomas, arcus cornea,tuberous xanthomas or xanthelasma)
☐ genetic testing
☐ LDL-C at least 190 mg/dL (prior to treatment with antihyperlipidemic agents)
☐ WHO criteria (Dutch Lipid Network clinical criteria, score greater than 5)
☐ Simon Broome criteria (“definite” or “possible” HeFH)
☐ none of the above

(if hyperlipidemia, primary or with ASCVD) Is there documentation that your patient has a contraindication per FDA label to statin therapy? ☐ Yes ☐ No
(if no contraindication) Is there documentation that your patient had intolerance to at least TWO statins? ☐ Yes ☐ No
(if intolerance) Is there documentation of the following?
☐ patient had symptoms or abnormal lab results that resolved when statin therapy was discontinued
☐ other causes of these symptoms or abnormal lab results were ruled out
☐ BOTH of the above
☐ neither of the above
(if NO intolerance) Was your patient treated with either of the following lipid lowering therapies?
☐ high-intensity statin therapy: atorvastatin/Lipitor 40-80 mg/day or rosuvastatin/Crestor 20-40 mg/day
☐ moderate-intensity or low-intensity statin therapy: atorvastatin 10-20mg/day, rosuvastatin 5-10mg/day, fluvastatin/Lescol XL, lovastatin/Altoprev/Mevacor, Livalo (pitavastatin), pravastatin/Pravachol, or simvastatin/Zocor
☐ none of the above
(if moderate/low-intensity) Does your patient have a history of documented intolerance to high-intensity statin therapy (atorvastatin/Lipitor 40-80 mg/day or rosuvastatin/Crestor 20-40 mg/day)? Yes ☐ No ☐

(if NO intolerance) Was your patient taking this statin therapy in combination with ezetimibe (Zetia)?
☐ Yes
☐ No, patient tried and had documented intolerance to ezetimibe
☐ No, patient has a contraindication per FDA label to ezetimibe
☐ No, patient is not a candidate for ezetimibe (for example, LDL-C lowering to achieve target exceeds 15-20%)
☐ No, due to other reason

(if NO intolerance) Was your patient maintained on this regimen for at least 12 consecutive weeks? Yes ☐ No ☐
(if yes) After at least 12 weeks, did your patient have an LDL-C greater than 70mg/dL (before adding Praluent)? Yes ☐ No ☐
Will this drug be used concurrently with evolocumab (Repatha) or in combination with lomitapide (Juxtapid)? Yes ☐ No ☐

Additional Pertinent Information: *(including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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