PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

# PCSK9 INHIBITORS INITIAL REQUEST FORM 6 MONTH APPROVAL

⊘ PLEASE DO NOT STAPLE

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Fax: 604 419-2689 | Toll-free fax: 1 844 419-2689 | pac.bluecross.ca

**HOW TO COMPLETE THIS FORM:**
**PLAN MEMBERS — Please complete RED portions of this form.**
**PHYSICIANS — Please complete BLACK portions of this form.**

Don't forget to sign *Part 8 — Member Consent and Declaration* before you submit your claim. DO NOT send genetic tests.

The patient is responsible for any fees charged by the physician for completion of this form. These fees are not eligible for reimbursement under your Pacific Blue Cross Extended Health Care plan.

Completion of this form does NOT imply approval for this drug. Coverage is based on the provisions of your Extended Health Care plan and Pacific Blue Cross qualification criteria.

## PART 1 — PLAN MEMBER TO COMPLETE

| Plan member's name | | Patient's name (if different than Plan member's name) | | |
|---|---|---|---|---|
| Patient's birthdate (mm-dd-yyyy) | Patient's weight | Patient's height | Policy number | ID number |

| Street address | City | Province | Postal code | Daytime phone number (10 digits) |
|---|---|---|---|---|

## PART 2 — PHYSICIAN TO COMPLETE

| Physician's name | College ID |
|---|---|

| Street address | City | Province | Postal code |
|---|---|---|---|

Physician's area of specialty: ☐ Cardiologist ☐ Endocrinologist ☐ Lipid specialist ☐ Internal medicine
☐ Other: _____

I certify the medical information provided is accurate and current:

| Physician's signature<br>X | Date (mm-dd-yyyy) |
|---|---|

## PART 3 — DRUG REQUESTED AND DIAGNOSIS

| | | |
|---|---|---|
| ☐ Evolocumab (Repatha™) | Strength | Dosage |
| ☐ Alirocumab (Praluent™) | Strength | Dosage |

Indication: ☐ Atherosclerotic Cardiovascular Disease (ASCVD)

For the treatment of Heterozygous Familial Hypercholesterolemia (HeFH), apply for BC PharmaCare Special Authority.
(Note: currently only Repatha will be considered. Praluent will not be covered for HeFH by BC PharmaCare or Pacific Blue Cross.)

## PART 4 — PATIENT INFORMATION (Check all that apply)

☐ Patient ≥ 18 years of age
☐ Acute coronary syndrome
☐ Myocardial infarction
☐ Stable or unstable angina
☐ Stroke or TIA
☐ Peripheral arterial disease
☐ Other, please specify:

_____

_____

_____

## PART 5 — CURRENT LIPID VALUES (Must submit lab report)

| LDL-C* | APO B | NON-HDL CHOLESTEROL | LIPID TEST DATE** |
|---|---|---|---|
| (mmol/L) | (g/L) | (mmol/L) | (mm-dd-yyyy) |

*LDL-C must be > 1.8 mmol/L on current therapy.

**Must be current within 90 days of this request

**Place your receipts loose and flat in the envelope — no staples, paperclips or tape. Also no cashier or Interac receipts.**

## PART 6 — LIPID LOWERING THERAPY HISTORY

| | | | | |
|---|---|---|---|---|
| Drug 1 | Name | Dosing regimen | Start date (mm-dd-yyyy) | End date (mm-dd-yyyy) or currently on |
| Response to therapy | | | | |
| Drug 2 | Name | Dosing regimen | Start date (mm-dd-yyyy) | End date (mm-dd-yyyy) or currently on |
| Response to therapy | | | | |
| Drug 3 | Name | Dosing regimen | Start date (mm-dd-yyyy) | End date (mm-dd-yyyy) or currently on |
| Response to therapy | | | | |
| Drug 4 | Name | Dosing regimen | Start date (mm-dd-yyyy) | End date (mm-dd-yyyy) or currently on |
| Response to therapy | | | | |
| Drug 5 | Name | Dosing regimen | Start date (mm-dd-yyyy) | End date (mm-dd-yyyy) or currently on |
| Response to therapy | | | | |

*Prior therapy of at least 3 months with ONE statin at maximally tolerated dose and Ezetimibe is required.

**Will current lipid therapy continue with PCSK9 inhibitor?** ☐ Yes ☐ No — If not, please explain why:

**Intolerance to or not at maximum statin dose:**

☐ Intolerable and persistent documented muscle symptoms (pain, weakness, cramps)
☐ Creatinine kinase (CK) levels greater than 10x upper normal limit and/or rhabdomyolysis
☐ Persistent serum transaminase levels greater than 3x upper normal limit
☐ Patient is non-adherent to statin therapy

## PART 7 — ADDITIONAL INFORMATION

## PART 8 — MEMBER CONSENT AND DECLARATION

**IMPORTANT: This section must be signed before submitting your form.**

I declare that all information in this form is true and complete. I understand Pacific Blue Cross will use the personal information on this form, and any other personal information they hold about me and my eligible dependents to determine eligibility for benefits and pay claims.

I acknowledge and agree that personal information about me and my eligible dependents may be collected, used and exchanged between Pacific Blue Cross and any other person or organization related to this claim or the administration of my benefit plan. This includes health care professionals, institutions, investigative agencies, insurers/re-insurers, government organizations or regulatory bodies. I acknowledge disclosure of my personal information by Pacific Blue Cross to my plan sponsor when required or permitted by law or pursuant to its contractual obligations under my benefit plan. I understand I may revoke this consent at any time and acknowledge that should I do so, this claim may not be considered.

If there is overpayment, I authorize its recovery from any amount payable to me under my benefit plan(s).

I have read and understand this Member Consent and Declaration and agree that a photocopy or digital version shall be as valid as the original and may remain in effect for the continued administration of this plan. I authorize my physician to release my personal information to Pacific Blue Cross to obtain approval for prescription benefit.

| Member's signature | Date (mm-dd-yyyy) |
|---|---|
| X | |