TRANSFORM
LDL-C Risk

PRIOR AUTHORIZATION CHECKLIST FOR USE OF PCSK9I IN SECONDARY PREVENTION OF ASCVD

- □ Documented LDL-C ≥70 obtained within the last 30 days
- □ Documented Clinical ASCVD (must be one of the items below to be considered ASCVD)
    - Acute coronary syndrome
    - Myocardial infarction
    - Stable or unstable angina
    - Coronary revascularization
    - Ischemic cerebrovascular accident or transient ischemic attack
- □ Documented previous high intensity statin trials or current use
    - Documented trial of two high intensity statins and symptoms of statin-related adverse effects
        - Statin name
        - Statin dose
        - Date prescribed (must be at least 90-day trial)
        - Documentation of statin-related adverse effects or contraindications if applicable
        - Documentation that symptoms resolved after discontinuation of treatment
    - Document statin currently used
- □ Documented ezetimibe trial or current use
    - Dose
    - Date prescribed
    - Symptoms of ezetimibe related adverse effects or contraindications if applicable

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PRIOR AUTHORIZATION NOTE TEMPLATE

[Date]

[Patient name] has a history of ASCVD as evidenced by [acute coronary syndrome, myocardial infarction, stable angina, unstable angina, coronary revascularization, cerebral vascular event, transient ischemic attack]. [He/She] had an LDL-C level of [XXX] mg/dL on [XX/XX/XXXX].

- IF TOLERATING STATIN:
    - [He/She] is currently taking [atorvastatin, rosuvastatin] on [XX/XX/XXXX] at a dose of [XX]mg [daily, every other day, weekly], but not reaching optimal LDL-c goal.

- IF INTOLERANT TO STATINS, COMPLETE BELOW:
- High Intensity statin #1: [He/She] was prescribed the high intensity statin [atorvastatin, rosuvastatin] on [XX/XX/XXXX] at a dose of [XX]mg [daily, every other day, weekly]. [He/She] returned for follow-up on [XX/XX/XXXX] with symptoms of [free text]. The dose was [reduced/discontinued] to [XX]mg [daily, every other day, weekly].
    - <IF DOSE REDUCED> Despite, the reduction in dose, [his/her] symptoms persisted, and the medication was discontinued on [XX/XX/XXXX] at which time, [his/her] symptoms resolved.
- High intensity statin #2: On [XX/XX/XXXX], [he/she] had an LDL-C of [XXX] mg/dL. The high intensity statin [atorvastatin, rosuvastatin] was prescribed. [He/She] was prescribed the high intensity statin [atorvastatin, rosuvastatin] on [XX/XX/XXXX] at a dose of [XX]mg [daily, every other day, weekly]. [He/She] returned for follow-up on [XX/XX/XXXX] with symptoms of [free text]. The dose was [reduced/discontinued] to [XX]mg [daily, every other day, weekly].
    - <IF DOSE REDUCED> Despite, the reduction in dose, [his/her] symptoms persisted, and the medication was discontinued on [XX/XX/XXXX] at which time, [his/her] symptoms resolved.

- Ezetimibe: [He/She] was prescribed [XX]mg daily of ezetimibe on [XX/XX/XXXX] and has reported [___/no] additional symptoms.
    - <IF ___>. These symptoms include [free text]. Ezetimibe was discontinued on [XX/XX/XXXX] and [his/her] symptoms resolved.

At this time, [his/her] LDL-C remains higher than the guidelines recommend – at [XXX] mg/dL – and [he/she] would benefit from intensifying [his/her] medication regimen to include [alirocumab/evolocumab] at a dose of [75/300]mg [every two weeks/monthly] to reduce their risk of future cardiovascular events in the future.