

Prescription Medication Prior Authorization Request Form



- Standard PA Request Urgent/Expedited PA Request

Please fill out all sections and attach any important documentation such as chart notes or lab results to support the PA request.
Once completed, submit to WithMe Health via fax at **1-866-678-8301**

Patient Information

Patient Name (Last, First, MI):		
Member ID Number:	Date of Birth:	Patient Phone Number:
Patient Address:		
Patient's Authorized Representative (If applicable):		Authorized Rep Phone Number:

Provider Information

Requesting Provider's Name:		
NPI:	Specialty:	
Office Address:		
Office Phone:	Office Fax:	
Office Contact Name:	Phone:	Fax:
Dispensing Pharmacy Name/Place of Service:	Phone:	Fax:

Requested Medication Information

Medication Name and Strength:		
Dose and Frequency (Sig):		
Qty Per 30 Days:	Expected Duration of Therapy:	
ICD-10(s):	Diagnosis:	
Please check one of the boxes below. If established, please include therapy start date:		
<input type="checkbox"/> New Therapy <input type="checkbox"/> Samples <input type="checkbox"/> Clinical Trial <input type="checkbox"/> Established Date Therapy Started: _____		

Previous Therapies Used for Diagnosis (Rx and OTC products)

Medication Name, Strength, Dose, Frequency	Dates Used	Outcome of Therapy (e.g., Ineffective, Not Tolerated)

Medical Rationale for Use of Requested Medication (**Please attach chart notes, lab work etc. when submitting this request. If applicable, please include why formulary therapies may be contraindicated for this patient.** Please also include which therapies will be used along with the requested medication. If patient is established on the requested medication, please include recent documentation of how the patient has responded to therapy.):

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Disease State Specific Questions

Please provide the following information:

1. Does the patient have a clinical diagnosis of atherosclerotic cardiovascular disease (ASCVD) or very high- risk ASCVD? Yes No
- a. Is this medication prescribed by or in conjunction with a specialist in cardiology, endocrinology, or lipid management? Yes No
- b. If yes, indicate specialty _____ Yes No
- Is the patient's most recent LDL-C is ≥ 70 mg/dL Yes No
- c. If yes, submit a copy of lab values Yes No
- d. Is the patient's age ≥ 18 years old? Yes No
2. Does the patient have a clinical diagnosis of primary hyperlipidemia, including heterozygous familial hypercholesterolemia (HeFH)? Yes No
- a. Is this medication prescribed by or in conjunction with a specialist in cardiology, endocrinology, or lipid management? Yes No
- b. Does the patient have a clinical diagnosis of FH using the Dutch Lipid Clinic Network Criteria or Simon Broome diagnosis criteria? Yes No
- c. Does the patient have an untreated LDL-C of ≥ 190 mg/dL (or ≥ 160 mg/dL in patients less than 20 years of age) with at least one of the following: Yes No
- Physical signs of FH (i.e. presence of tendon xanthomas, premature corneal arcus, tuberous xanthomas, or xanthelasma) **OR**
 - Family history of FH
- d. Has the patient had genetic testing confirms the presence of a mutation for FH that affects LDL-C functionality (i.e. a mutation in the LDLR, APOB, or PCSK9 genes)? Yes No
- e. Is the patient's most recent LDL-C is ≥ 100 mg/dL? If yes, submit copy Yes No
3. Does the patient have a clinical diagnosis of homozygous familialhyperlipidemia (HoFH)? Yes No
- a. Is the medication prescribed by or in conjunction with a specialist in cardiology, endocrinology, or lipid management? Yes No
- b. Does the patient have an untreated LDL-C of > 500 mg/dL (or a treated LDL-C ≥ 300 mg/dL) with either: Yes No
- Cutaneous or tendon xanthomata before the age of 10 years **OR**
 - Diagnosis of heterozygous familial hypercholesterolemia (HeFH) in both parents?
- c. Has the patient had Genetic testing confirms the presence of two mutations for FH that affect LDL-C functionality (i.e. mutations in the LDLR, APOB, or PCSK9 genes)? Yes No
- d. If the patient is ≥ 18 years, is their the most recent LDL-C is ≥ 70 mg/dL? Yes No
If yes, submit copy of lab results
- e. If the patient is < 18 years is their most recent LDL-C is ≥ 135 mg/dL. Yes No
If yes, submit a copy of lab results
- f. Is the patient's age ≥ 13 years old? Yes No

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by WithMe Health, the health plan sponsor, or, if applicable, a state or federal regulatory agency.

Provider Signature

Date

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