TeamstersCare

PCSK9 Inhibitor Prior Authorization Form

Phone: 617-241-9024
Fax: 617-241-5025

PHYSICIAN INFORMATION	PATIENT INFORMATION
Name/Degree:	Patient Name:
Specialty: Board Certified: Yes____No____	TeamstersCare ID #:
Address:	DOB:
City, State, Zip:	Address:
Phone:	City, State, Zip:
Fax:	Phone:

Patient's diagnosis related to PCSK9 therapy:

Other significant factors:

Cholesterol/Weight

	Total Cholesterol	LDL	HDL	Triglycerides	BMI
Current					
6 Months Ago					
1 Year Ago					

PCSK9 Inhibitor Requested: _____

Current Lipid-Modifying Therapy (include drug name, strength and dose)

History of Lipid-Modifying Therapy
(Include drug name, strength, dose, dates of therapy and reason for discontinuation)

Name of drug, strength, dose	Therapy Start Date	Therapy End Date	Reason for Discontinuation
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	

Please send a copy of most recent office visit notes.

Provider Signature _____ Date_____

FOR TEAMSTERSCARE USE ONLY

Eligibility Verified_____

Program: ACTIVE ____ ERMP____RRX_____

Prior PA? Yes____No____ If Yes, Date: _____

Form Complete/Legible _____

Authorized _____ Pended _____ Denied_____

Patient Notified _____ By:_____ Date: _____

Letter Sent ____ By:_____ Date:_____

Notes:

Reviewer: _____ Date: _____