South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-22941

PHONE: 605-773-3495 | FAX: 605-773-5246
WEB: DSS Medicaid Prior Authorizations | **EMAIL :** DSSMedicaidpa@state.sd.us

LEQVIO PRIOR AUTHORIZATION REQUEST FORM

This form **MUST BE** submitted with medical records to support services

Date:		
RECEIPIENT INFORMATION		
Medicaid ID:	**Date of Birth:**	**Sex:** M ☐ F ☐
Last Name:	**First Name:**	
GENERAL INFORMATION		
First Date of Service:	**Last Date of Service:**	
Primary Diagnosis Code:	**HCPC Code:**	
Drug Name:	**Quantity:**	
Hospitalizations/Treatments/Medications Used in the last 6 months:		
POINT OF CONTACT		
Name and Title:		
Email:	**Phone:**	**Fax:**
Note: *The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA. The determination notice will be sent to the listed point of contact.*		
REFERRING PROVIDER INFORMATION		
Name:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	
SERVICING PROVIDER INFORMATION		
Name:		
Address:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	

CRITERIA	
☐	**Medical records to support use of product are submitted**
Initial Therapy (check one)	**Yes** ☐ **No** ☐
☐	Individual has a diagnosis of **one** of the following: ☐ Heterozygous familial hypercholesterolemia as evidenced by mutation in the LDLR, ApoB, PCSK9 or ARH adapter protein gene ☐ History of clinical ASCVD as indicted by **one** of the following: ☐ Acute coronary syndrome ☐ Coronary artery disease (CAD) ☐ History of myocardial infarction (MI) ☐ Stable or unstable angina ☐ Coronary or other arterial revascularization ☐ Stroke ☐ Transient ischemic attack (TIA) ☐ Peripheral arterial disease (PAD) ☐ ASCVD risk ≥20%
☐	Individual meets **one** of the following regarding statin therapy ☐ Individual is currently taking high intensity statin therapy (high intensity statin is defined at atorvastatin ≥40mg or rosuvastatin ≥20mg) and has been compliant with therapy for ≥3 months ☐ Individual is statin intolerant based on **one** of the following ☐ Inability to tolerate at least two statins, with at least one started at the lowest daily starting dose ☐ Development of statin associated rhabdomyolysis or immune-mediated necrotizing myopathy (IMNM) after a trial of one statin ☐ Individual has a contraindication to statin therapy including but not limited to active liver disease, unexplained persistent elevation of hepatic transaminases or pregnancy
☐	Individual meets **one** of the following regarding ezetimibe therapy ☐ Individual is currently taking at a dose of 10mg daily and has been compliant with therapy for ≥3 months ☐ Individual has had a trial and inadequate response to ezetimibe therapy ☐ Individual is intolerant of ezetimibe as documented by provider
☐	Individual meets **one** of the following regarding proprotein convertase subtilisin kexin type 9 (PCSK9) inhibitor therapy ☐ Individual has had a trial and inadequate response to PCSK9 therapy as indicated by LDL reduction of ≤50% from baseline ☐ Individual is intolerant of PCSK9 therapy ☐ Documentation is provided that individual is LDLR negative
☐	Documentation is provided indicating baseline lipid panel and comprehensive metabolic panel (CMP) were completed prior to starting therapy with Leqvio

☐	Therapy will not be used in combination with Praluent, Repatha, Juxtapid or Evkeeza	
☐	Individual is ≥18 years of age	
Continuation of Therapy (check one)	**Yes** ☐	**No** ☐
☐	Individual continues to use with high intensity statin (unless requirement previously waived for contraindication/therapy failure)	
☐	Individual has had a positive response to therapy as indicated by a reduction in total LDL-C	

PHYSICIAN SIGNATURE – PROVIDER ONLY

This form must be signed by a provider

☐	I certify that the information given in this form is a true and accurate medical indication for the required product

Name & Title (Printed):	**Specialty:**
Signature:	