ADVANCED PRIOR AUTHORIZATION REQUEST

Hypercholesterolemia (High Cholesterol)

INSTRUCTIONS:

1. Please have your physician indicate whether this is an INITIAL prior authorization request or a RENEWAL request by checking the appropriate box in PART 5: PRESCRIBER INFORMATION and then completing ONLY the noted sections.
2. Please have your physician submit the completed form to Merit Mercon Benefits by email at PA@merconbenefits.com or by fax at 1 (780) 455-6068.
3. If you or your physician have any questions about the prior authorization process, please contact a Plan Administrator at Merit Mercon Benefits at 1 (877) 263-7266 (toll-free) or (780) 455-5845 (Edmonton).
4. Consent is being obtained in accordance with Schedule 1 of the federal Personal Information Protection Electronic Documents Act. If you have any questions regarding the collection, use and disclosure of your personal information, please contact Merit Mercon Benefits' Privacy Officer at 1 (877) 263-7266 (toll-free) or (780) 455-5845.

PART 1: PATIENT INFORMATION

Plan Member Name:	Patient Name:	Patient's Date of Birth (YYYY/MM/DD):
Policy Number:	Certificate Number:	If you (the patient) are someone other than the covered member, please indicate your relation to the covered member: ☐ Spouse ☐ Dependent
Address (number, street, city, province, postal code):		
Phone: _____	E-mail: _____	
Note: Phone is for clarification/request for additional information only		

PART 2: COORDINATION OF BENEFITS

Are you currently on, or have previously been on this medication? ☐ Yes ☐ No	If Yes, Start date: (YYYY/MM/DD): _____ Coverage provided by: _____
Do you or your dependants have health benefit coverage through another health benefits company or insurance company? ☐ Yes ☐ No	If Yes, Name of other health benefits company/insurance company: _____ Name of person holding coverage: _____

Are you currently receiving disability benefits (short-term or long-term) for the condition for which this medication has been prescribed?
☐ Yes ☐ No

Have you applied for coverage or received any financial support for this medication:

From another **insurance plan**? ☐ Yes ☐ No	If Yes, name of covered family member: _____ Relationship: _____ Name of Insurance Company: _____ Outcome: _____
From a **provincial program**? ☐ Yes ☐ No	If Yes, name of program(s): _____ **Please attach documentation of acceptance or declination** If No, please explain why the application has not been made: _____
From a **patient assistance / compassionate use program**? ☐ Yes ☐ No	If Yes, name of program(s): _____ Patient assistance program contact name and phone number: Contact Name: _____ Phone number: _____

PART 3: CURRENT/PAST PHARMACY INFORMATION		
Please provide contact details of the pharmacy/pharmacies from which the patient has received medications over the last two years.		
Pharmacy Name	Location (Street and City)	Phone #

PART 4: CONSENT TO COLLECTION, USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

As of the date hereof, I hereby authorize any person or organization who has personal health information about me, including any health care professional (which includes but is not limited to physicians, medical specialists, physiotherapists, pharmacists or any other person who has examined or treated me), health care institution, pharmacy and other medical-related facility, and any authorized agent of mine to release and disclose to Cubic Health Inc. ("Cubic") any personal information regarding my past medical history and current medical condition, including any relevant clinical notes (collectively, the "Personal Information"), which may be required to adjudicate the Request for Prior Authorization to which this Consent forms a part (the "Request").

I authorize Cubic to collect, use and maintain any Personal Information it deems necessary for the purposes of adjudicating the Request or any purposes in any way ancillary thereto.

I understand and agree that Cubic will keep any Personal Information obtained from such persons, organizations and/or agents secure and confidential and in accordance with applicable legislation and that my personal information will not be shared with any other party.

I hereby acknowledge and understand that:

- access to my Personal Information will be limited to Cubic pharmacists and other employees in the course of their employment;
- by filling out the Request, I am not guaranteed approval for any level of coverage;
- Cubic is an independent clinical review panel and is not affiliated with my employer, plan sponsor, plan administrator or insurance company and that Cubic has been engaged for the purpose of ensuring that criteria for the approval of claims are satisfied before approval is granted, and to ensure that the criteria for coverage are implemented consistently;
- Cubic has no interest, financial or otherwise, in the decision rendered in adjudicating the Request;
- Cubic specifically assumes no responsibility for the completeness or accuracy of any Personal Information which may be provided to Cubic in connection with the Request, and Cubic disclaims all liability for any loss or damage suffered by any person, including (without limitation) me, as a result of the processing or outcome of the Request; and
- I have no claim against Cubic for any loss or damage (direct, indirect, incidental, consequential or otherwise) I may suffer as a result of the handling, processing or outcome of the Request.

I understand and agree to the terms above (*If patient is <18 years old, parent/guardian to sign below).*

_____	_____	_____
Full Name (please print)	Signature	Date Signed (YYYY/MM/DD)

MERIT
mercon benefits

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Remainder of form to be completed by Physician/Specialist

PART 5: PRESCRIBER INFORMATION

Physician/Prescriber Name:	Specialty:
Registration Number:	Telephone Number:
Address (number, street, city, province, postal code):	Fax Number *(Must be submitted with each request)*:

This request is a: ☐ New Request (please complete *only* Parts 6-9) ☐ Renewal Request (please complete *only* Parts 6 and 10)

PART 6: MEDICATION REQUESTED

Alirocumab:
☐ Praluent 75mg/mL pen
☐ Praluent 75mg/mL prefilled syringe
☐ Praluent 150mg/mL pen
☐ Praluent 150mg/mL prefilled syringe

Evolocumab:
☐ Repatha 140mg/mL syringe/autoinjector

Other:

Directions for use (i.e. prescription sig):

Where will treatment be administered (e.g. home, physician's office, specialty clinic, hospital)?

Name of facility: _____

PART 7: CLINICAL INFORMATION

Anticipated duration for treatment *(max. approval is one year before renewal required)*	Current patient weight:

Does patient have any relevant drug allergies? ☐ Yes ☐ No

Nature of allergy, if applicable:_____

What is the patient's diagnosis:

☐ **Atherosclerotic Cardiovascular disease (ASCVD)**

☐ **Heterozygous familial hypercholesterolemia (HeFH) confirmed using the Simon Broome criteria:**
- ☐ LDL-C level of > 4.9 mmol/L PLUS at least one of the following:
  - ☐ Physical finding = tendon xanthomas, or tendon xanthomas in first or second degree relative; OR
  - ☐ DNA-based evidence of an LDL-receptor mutation, familial defective apo B-100, or a PCSK9 mutation; OR
  - ☐ Family history of myocardial infarction before the age of:
    - 50 Years, in any first- or second-degree relative
    - 60 Years, in any first-degree relative

☐ **Homozygous familial hypercholesterolemia (HoFH) confirmed by:**
- ☐ Patient had documented baseline LDL-C >13mmol/L at diagnosis

PLUS one of the following:
- ☐ Physician has provided DNA-based evidence of two mutant alleles to confirm diagnosis; OR
- ☐ Tendon xanthomas are present in the patient; OR
- ☐ Evidence of heterozygous familial hypercholesterolemia in both parents.

Please provide documentation to confirm presence of HeFH or HoFH and attach patient's cholesterol work-up or complete blood count

Does the patient have a documented history of one of the following cardiovascular events? If yes, check all that apply and provide documentation:

☐ Acute coronary syndrome
☐ Myocardial infarction
☐ Stable/unstable angina
☐ Transient ischemic attack/stroke
☐ Peripheral arterial disease presumed to be of atherosclerotic origin
☐ Coronary or other arterial revascularization procedure
☐ Findings from CT angiogram or catheterization with clinical ASCVD

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PART 8: RELEVANT CURRENT/PREVIOUS THERAPIES				
Name of statin	**Dosing Regimen**	**Start Date** (MM/YYYY)	**End Date** (MM/YYYY)	**Patient Response or Reason for Discontinuation** (details of intolerance/failure at maximum doses must be provided)
				□ Persistent myopathy or myalgia (muscle pain, ache, or weakness without CK elevation) for at least 2 weeks □ Myositis (muscle symptoms with increased CK levels). Please submit CK levels. □ Rhabdomyolysis (muscle symptoms with marked CK elevation). Please submit CK levels. □ Other:
				□ Persistent myopathy or myalgia (muscle pain, ache, or weakness without CK elevation) for at least 2 weeks □ Myositis (muscle symptoms with increased CK levels). Please submit CK levels. □ Rhabdomyolysis (muscle symptoms with marked CK elevation). Please submit CK levels. □ Other:
				□ Persistent myopathy or myalgia (muscle pain, ache, or weakness without CK elevation) for at least 2 weeks □ Myositis (muscle symptoms with increased CK levels). Please submit CK levels. □ Rhabdomyolysis (muscle symptoms with marked CK elevation). Please submit CK levels. □ Other:

PART 9: ADDITIONAL INFORMATION

Please provide/attach all relevant clinical information to support medical necessity of medication therapy requested including any relevant lab tests which may support choice of medication therapy:

PART 10: RENEWAL COVERAGE CRITERIA

Date patient started current medication (MM/YYYY):	Current LDL-C:	Pre-treatment LDL-C:

Please provide/attach any additional clinical information to support the renewal of the requested medication:

I certify that the information provided is true, correct, and complete. Please be advised further information may be requested if needed to facilitate determination of coverage.

Prescribing Physician's signature: ____ Date (YYYY/MM/DD): ____________________________