

Special Authorization Request Form, for:

REPATHA (*evolocumab*)

The purpose of this form is to obtain medical information required to assess your request for a drug on the Special Authorization (SA) list of the Reformulary. Please ensure that all information, including contact information, is complete. Completing this form is not a guarantee of approval.

PART 1: COMPLETE THIS INFORMATION

Information about plan member

First name: _____ Last name: _____

Group number: _____ Certificate number: _____

Date of birth (DD/MM/YY): _____ Gender: _____

Address: _____

City/Town: _____ Province: _____ Postal code: _____

Email: _____ Phone: _____

COORDINATION OF BENEFITS

Coverage through another health benefit plan or provincial plan

Do you or your dependents have drug coverage through another health benefits, insurance company or provincial plan? Yes No

If yes, provide the following: Name of plan member: _____

Policy/Plan number: _____ Certificate number: _____

Patient assistance program

Have you enrolled in a patient assistance program? Yes No

If yes, provide your patient assistance program ID number: _____

Provide the patient assistance program:

Contact name: _____ Phone: _____

PART 2: TO BE COMPLETED BY YOUR DOCTOR (PHYSICIAN)

Physician Information

First name: _____ Last name: _____

License: _____ Phone: _____

Address: _____

City/Town: _____ Province: _____ Postal code: _____

Physician's signature: _____

(confirming the below information to be correct)

Drug being requested through Special Authorization

New request Request for continuation of therapy

DIN: _____ Product name: _____

Strength: _____ Dosage: _____

Site of Administration

Home Private clinic Hospital
 Doctor's office Cancer centre LTC facility

CLINICAL INFORMATION

Diagnosis

- Homozygous Familial Hypercholesterolemia (HoFH)
- Heterozygous Familial Hypercholesterolemia (HeFH)
- Atherosclerotic Cardiovascular Disease

Physician specialty

- Cardiologist
- Endocrinologist
- Lipid specialist

CLINICAL INFORMATION (cont.)

Criteria for initial coverage, confirm the following:

For Homozygous Familial Hypercholesterolemia (HoFH)

- Patient is 10 years of age or older; and
- Patient has definite or probable diagnosis of FH using the Simon Broome or Dutch Lipid Network criteria or genetic testing; and
- LDL-C* is persistently above the goal of therapy, despite receiving moderate to high intensity (OR maximally tolerated) statin therapy (when not contraindicated/intolerant) with or without other standard lipid-lowering therapy for at least 4 weeks

For Heterozygous Familial Hypercholesterolemia (HeFH)

- Patient is 10 years of age or older; and
- Patient has definite or probable diagnosis of FH using the Simon Broome or Dutch Lipid Network criteria or genetic testing; and
- LDL-C* is persistently above the goal of therapy, despite receiving moderate to high intensity (OR maximally tolerated) statin therapy (when not contraindicated/intolerant) with or without other standard lipid-lowering therapy for at least 4 weeks

For ASCVD (atherosclerotic cardiovascular disease)

- Patient is 18 years of age or older; and
- Patient has atherosclerotic cardiovascular disease (ASCVD) such as:
 - Prior myocardial infarction (MI) **OR** Other ASCVD conditions such as prior non-hemorrhagic stroke or transient ischemic attack (TIA), symptomatic peripheral arterial disease (PAD), acute coronary syndrome (ACS) or unstable angina, chronic coronary artery disease, coronary or other arterial revascularization; and
- LDL-C* is persistently above the goal of therapy despite receiving maximally tolerated doses of statin therapy (when not contraindicated/intolerant) with or without other LDL-lowering therapies for at least 4 weeks

NOTE: Duration of initial approval is 12 months

*CCS Guidelines support LDL-C as the primary target of therapy but alternatives may be required if patients have a triglyceride 1.5mmol/l or greater. In this setting LDL-C is an invalid goal of therapy and CCS guidelines recommend use of the alternative goals of either non-HDL-C or apoB100.

Request for continuation of therapy, confirm the following:

For Familial Hypercholesterolemia (homozygous and heterozygous) and ASCVD (atherosclerotic cardiovascular disease)

- There is documented evidence of continued achievement of lipid goals of therapy in conjunction with maximally tolerated statin (when not contraindicated), with or without other standard lipid lowering therapies

NOTE: Duration of continued approval is 12 months

SPECIAL NOTES

Describe any intolerances to therapy: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information that the physician believes is important to this review? _____

Date: March 2023