145 The West Mall, P.O. Box 110 U
Toronto, ON M8Z 5M4

PRIOR AUTHORIZATION PROGRAM FORM

Repatha® (Evolocumab)

Instructions:

1. Section 1 to be completed by Plan Member/ Patient
2. Section 2 to be completed by Physician/ Pharmacist (expenses incurred by the completion of this form is at plan member's expense)
3. Section 3 to be completed by Pharmacist.

Please fax completed form to NexgenRx Formulary Management to 1-877-639-4369 or mail to 145 The West Mall P.O. Box 110 U, Toronto, Ontario,M8Z-5M4

Section 1: To be completed by Patient

Member's Name: (Last , First)	Card ID Number:	
Patient's Name: (Last, First)	Patient's Date of Birth (dd/mm/yy)	Relationship to Member (please circle) Employee Spouse Dependent	PATIENT CODE

Results of this request to be communicated to:

☐ Pharmacy	☐ Patient / Legal Guardian Named Below	☐ email:

I authorize NexgenRx Inc. (a) to use the personal information disclosed on this form, and any other personal information known to NexgenRx Inc. regarding the above-named patient, for the purpose of assessing this prior authorization request and any related claim and administering the benefit plan under which any such claim is made, and (b) to contact, and to obtain any such personal information from and to disclose any such personal information to, any physician, pharmacist or other health care professional having knowledge of such patient's health relevant to this request and any related claim.

Patient / Legal Guardian Name: ____________________ Telephone Number: ____________________

Signature of Patient/ Legal Guardian: ____________________ Date (dd/mm/yy):____________________

Section 2: To be completed by Physician/ Pharmacist

Drug Name & Strength:	DIN: 02446057	Dosage Instructions:

Eligibility for drug coverage is dependent upon the patient meeting at least one of the qualifying criteria listed below. If the patient has another drug plan, prior authorization may cover some or all of the excess not paid by the primary plan.

Please indicate if the patient meets at least one of the following qualifying criteria for drug coverage:

☐ Primary Hyperlipidemia :Repatha is indicated as an adjunct to diet and maximally tolerated statin therapy in adult patients with heterozygous familial hypercholesterolemia (HeFH) or clinical atherosclerotic cardiovascular disease (CVD), who require additional lowering of low density lipoprotein cholesterol (LDL-C). The effect of REPATHA on cardiovascular morbidity and mortality has not been determined.

☐ Homozygous Familial Hypercholesterolemia **:**Repatha is indicated as an adjunct to diet and other LDL-lowering therapies (e.g., statins, ezetimibe, LDL apheresis) in adult patients and adolescent patients aged 12 years and over with homozygous familial hypercholesterolemia (HoFH) who require additional lowering of LDL-C.

Physician / Pharmacist Name: (Last, First)	License Number:
Address: (Street, City, Province, Postal Code)	Telephone Number : ( ) - Fax Number: ( ) -
Signature of Physician / Pharmacist:	Date (dd/mm/yy)

Section 3: To be completed by Pharmacist

Pharmacy Name:	Provider Number:
Pharmacy Address: (Street, City, Province, Postal Code)	Telephone Number : ( ) - Fax Number: ( ) -
Signature of Pharmacist: ____________________ Pharmacist's Name: (Print Last, First) ____________________	

Internal Office Use Only:

Date Received:			Date Approved: