

**NC Division of Medical Assistance  
Outpatient Pharmacy  
Prior Approval Criteria  
PCSK9 Inhibitors**

**Medicaid and Health Choice  
Effective Date:**

**DRAFT**

**Therapeutic Class Code: M4T**

**Therapeutic Class Description: Antihyperlipidemic - PCSK9 Inhibitors**

Medications	Generic Code Number(s)	NDC Number(s)
Praluent® (alirocumab)	31981, 31982, 31983, 31984	
Repatha™ (evolocumab)	38178, 39363	

**Eligible Beneficiaries**

NC Medicaid (Medicaid) beneficiaries shall be enrolled on the date of service and may have service restrictions due to their eligibility category that would make them ineligible for this service.

NC Health Choice (NHC) beneficiaries, ages 6 through 18 years of age, shall be enrolled on the date of service to be eligible, and must meet policy coverage criteria, unless otherwise specified.

**EPSDT Special Provision: Exception to Policy Limitations for Beneficiaries under 21 Years of Age**

**42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiaries under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

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**EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid and NC Health Choice Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

***Basic Medicaid and NC Health Choice Billing Guide:***

<http://www.ncdhhs.gov/dma/basicmed/>

**EPSDT provider page:** <http://www.ncdhhs.gov/dma/epsdt/>

**Health Choice Special Provision: Exceptions to Policy Limitations for Health Choice Beneficiaries ages 6 through 18 years of age**

**EPSDT does not apply to NCHC beneficiaries.** If a NCHC beneficiary does not meet the clinical coverage criteria within the **Outpatient Pharmacy prior approval** clinical coverage criteria, the NCHC beneficiary shall be denied services. Only services included under the Health Choice State Plan and the DMA clinical coverage policies, service definitions, or billing codes shall be covered for NCHC beneficiaries.

**Criteria for all PCSK9 Inhibitors**

- Beneficiary must be 18 years of age or older and under 75 years of age  
**AND**
- Beneficiary must have a diagnosis Heterozygous Familial Hypocholesteremia  
**OR**
- Beneficiary must have clinical atherosclerotic cardiovascular disease such as heart attack or stroke  
**AND**
- Beneficiary is currently taking **high maximum** dose atorvastatin (generic for Lipitor®) or rosuvastatin (generic for Crestor®) **for their age** and has completed 90 days of treatment.  
**Provider must verify adherence through consultation with the beneficiary's pharmacy.**
  - Beneficiary's LDL level is **greater or equal to 130 mg/dl** after taking atorvastatin (generic for Lipitor®) or rosuvastatin (generic for Crestor®) for 90 days.
  - For intolerance to atorvastatin (generic for Lipitor®) or rosuvastatin (generic for Crestor®), trial and failure of both of these statins at lower dose must be utilized and documented.
    - **Clinically significant intolerance or allergic reaction to statin treatment must be documented and attached to the prior authorization. Examples of significant intolerance includes severe muscle pain, significant liver abnormalities, and rhabdomyolysis. Intolerance does not include fatigue, cognitive impairment, or mild aches.**
- Baseline LDL labs prior to any treatment and labs after previous treatments showing inadequate control on statins must be attached to the initial prior authorization request.

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**AND**

- Beneficiary must continue both PCSK9 Inhibitor and high dose atorvastatin (generic for Lipitor®) or rosuvastatin (generic for Crestor®) to continue therapy unless otherwise approved due to intolerance.

**Criteria for alirocumab (Praluent®)**

- Beneficiary must have a diagnosis Heterozygous Familial Hypocholesteremia

**OR**

- Beneficiary must have clinical atherosclerotic cardiovascular disease such as heart attack or stroke

**Criteria for evolocumab (Repatha®)**

- Beneficiary must have a diagnosis Heterozygous (HeFH) or Homozygous Familial Hypocholesteremia (HoFH)

- For patients with a diagnosis of HoFH, the age limit is 13 years and older.

**OR**

- Beneficiary must have clinical atherosclerotic cardiovascular disease such as heart attack or stroke

**References**

1. Drug Effectiveness Review Project: Propoprotein Convertase Subtilisin Kexin type 9 (PCSK9) Inhibitors Draft Original Report, May 2015, Kim Peterson, MS, Brittany Holzhammer, MPH, Marian McDonagh, PharmD
2. Drug Effectiveness Review Project: Propoprotein Convertase Subtilisin Kexin type 9 (PCSK9) Inhibitors Draft Original Report-Appendixes and Evidence Tables, May 2015, Kim Peterson, MS, Brittany Holzhammer, MPH, Marian McDonagh, PharmD
3. Praluent® (alirocumab) package insert. ©2015 Regeneron Pharmaceuticals, Inc./ sanofi-aventis U.S. LLC
4. Blom DJ, Hala T, Bolognese M, et al. A 52-week Placebo-Controlled Trial of Evolocumab in Hyperlipidemia. N Engl J Med 2014; 370:1809-19.
5. Repatha™ (evolocumab) package insert v2. ©2015 Amgen, Inc.