Initial Approval: January 8, 2014

CRITERIA FOR PRIOR AUTHORIZATION

Kynamro® (mipomersen)

PROVIDER GROUP Pharmacy Professional

MANUAL GUIDELINES The following drug requires prior authorization:
Mipomersen (Kynamro)

CRITERIA FOR HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HOFH): (must meet all of the following)

- Patient must have a diagnosis of homozygous familial hypercholesterolemia based on the presence of one of the following:
  - Genetic confirmation of two mutant alleles at the LDL receptor, ApoB, PCSK9, or ARH adaptor protein gene locus
  - An untreated LDL-cholesterol concentration >500mg/dL (13mmol/L)
  - Treated LDL-cholesterol ≥300mg/dL (7.76mmol/L) AND one of the following:
    - Cutaneous or tendonous xanthoma before 10 years of age
    - Untreated LDL cholesterol levels consistent with heterozygous FH in both parents (>190mg/dL)

LENGTH OF APPROVAL 12 months