HEALTH PARTNERS PLANS
Phone 215-991-4300 Fax 1-866-240-3712

FAX FORM AND CLINICAL DOCUMENTATION

LIPOTROPICS, OTHER PRIOR AUTHORIZATION FORM *(form effective 1/6/2025)*

Prior authorization guidelines **Lipotropics, Other** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.pa.gov/en/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services.html.

☐New request ☐Renewal request	Total pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:	
Dose/directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

1. For treatment of ANY LIPID DISORDER:
☐Has results of a lipid profile within the past 3 months

2. For a PCSK9 INHIBITOR (eg, Leqvio, Praluent, Repatha), NEXLETOL (bempedoic acid), or NEXLIZET (bempedoic acid/ezetimibe):
☐One of the following related to history of **statin** use:
- ☐Failed to achieve goal LDL-C or percentage reduction of LDL-C with maximally tolerated dose of ONE high-intensity statin (eg, atorvastatin, rosuvastatin) for at least THREE consecutive months
- ☐Is unable to tolerate high-intensity statins AND:
  - ☐Has a temporally related intolerance to high-intensity statins
  - ☐Tried and failed or has an intolerance to the lowest FDA-approved daily dose or alternate-day dosing of any statin for at least THREE months
  - ☐Modifiable comorbid conditions that may enhance statin intolerance were ruled out and/or addressed by the prescriber (eg, drug interactions, hypothyroidism, vitamin D deficiency, etc.)
- ☐Has a contraindication to statins

☐One of the following related to history of **ezetimibe** use:
- ☐Failed to achieve goal LDL-C or percentage reduction of LDL-C with ezetimibe in combination with maximally tolerated dose of

the highest-tolerated intensity statin (eg, atorvastatin, rosuvastatin) for at least THREE consecutive months

- ☐ Has a contraindication or an intolerance to ezetimibe
- ☐ **For a PCSK9 inhibitor,** has an LDL-C that is >25% above goal LDL-C while adherent to treatment with the maximally tolerated dose of the highest-tolerated intensity statin for at least THREE consecutive months

☐ One of the following:

- ☐ For a diagnosis of homozygous familial hypercholesterolemia, is prescribed the requested medication in addition to other standard lipid-lowering therapies
- ☐ For all other diagnoses, is prescribed the requested medication in addition to the maximally tolerated dose of the highest-tolerated intensity statin (if clinically appropriate)

☐ **For a non-preferred PCSK9 inhibitor:**

- ☐ Tried and failed a preferred PCSK9 inhibitor or has a contraindication or an intolerance to the preferred PCSK9 inhibitors approved or medically accepted for the treatment of the beneficiary's diagnosis (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

☐ **For Nexletol (bempedoic acid) or Nexlizet (bempedoic acid/ezetimibe):**

- ☐ If currently taking simvastatin or pravastatin, will not be using Nexletol/Nexlizet concomitantly with simvastatin at a dose of >20 mg daily or pravastatin at a dose of >40 mg daily

3. For EVKEEZA (evinacumab) or JUXTAPID (lomitapide):

☐ Is prescribed the requested medication by or in consultation with a cardiologist, endocrinologist, or other provider specializing in lipid disorders

☐ One of the following:

- ☐ Tried and failed or has a contraindication or an intolerance to PCSK9 inhibitors
- ☐ Is homozygous for LDL receptor (LDLR)-negative mutations (ie, has LDLR-negative mutations in both alleles) associated with LDLR activity below 2%

☐ Is prescribed the requested medication in addition to other standard lipid-lowering therapies

4. For VASECPA (icosapent ethyl):

☐ One of the following:

- ☐ Has a history of clinical atherosclerotic cardiovascular disease
- ☐ Both of the following:
  - ☐ Has diabetes mellitus
  - ☐ Has at least 2 additional ASCVD risk factors AND *(check all that apply)*:
    - ☐ age ≥50 years
    - ☐ cigarette smoking
    - ☐ hypertension
    - ☐ hs-CRP >3.00 mg/L
    - ☐ CrCl <60 mL/min
    - ☐ HDL-C ≤40 mg/dL for males or ≤50 mg/dL for females
    - ☐ retinopathy
    - ☐ micro- or macroalbuminuria
    - ☐ ABI <0.9
    - ☐ other: _____
- ☐ Tried and failed or has a contraindication or an intolerance to the preferred Lipotropics, Other approved or medically accepted for the treatment of the beneficiary's diagnosis (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

☐ Has fasting triglycerides ≥150 mg/dL

☐ One of the following:

- ☐ Tried and failed maximally tolerated doses of TWO different high-intensity statins for at least THREE months each
- ☐ Has a history of statin intolerance after modifiable risk factors have been addressed (eg, drug interactions, hypothyroidism, vitamin D deficiency, etc.)
- ☐ Has a contraindication to statins

5. For ALL OTHER NON-PREFERRED Lipotropics, Other:

☐ Tried and failed or has a contraindication or an intolerance to the preferred Lipotropics, Other approved or medically accepted for the beneficiary's diagnosis *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

RENEWAL requests

1. For ALL diagnoses:

☐ Experienced a positive clinical response demonstrated by lab test results, if appropriate for the diagnosis, since starting the requested medication (e.g., decreased LDL-C, decreased triglycerides, etc.)

2. For a PCSK9 INHIBITOR (eg, Leqvio, Praluent, Repatha):

☐ For a diagnosis of homozygous familial hypercholesterolemia, is using the requested PCKS9 inhibitor in addition to other standard lipid-lowering treatments

☐ For all other diagnoses, is using the requested PCSK9 inhibitor in addition to the maximally tolerated dose of the highest-tolerated intensity statin (if clinically appropriate)

3. For NEXLETOL (bempedoic acid) or NEXLIZET (bempedoic acid/ezetimibe):

☐ Is using the requested medication in addition to the maximally tolerated dose of the highest-tolerated intensity statin (if clinically appropriate)

☐ If currently taking simvastatin or pravastatin, will not be using Nexletol/Nexlizet concomitantly with simvastatin at a dose of >20 mg daily or pravastatin at a dose of >40 mg daily

4. For EVKEEZA (evinacumab) or JUXTAPID (lomitapide):

☐ Is prescribed the requested medication by or in consultation with a cardiologist, endocrinologist, or other provider specializing in lipid disorders

☐ Is using the requested medication in addition to other standard lipid-lowering treatments

5. For ALL OTHER NON-PREFERRED Lipotropics, Other:

☐ Tried and failed or has a contraindication or an intolerance to the preferred Lipotropics, Other approved or medically accepted for the beneficiary's diagnosis *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 866-240-3712

Prescriber Signature:	**Date**: