# LIPOTROPICS, OTHER PRIOR AUTHORIZATION FORM

(form effective 1/6/2025)

Community HealthChoices | AmeriHealth Caritas Pennsylvania | PERFORMRX℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-855-851-4058**, or to speak to a representative call **1-888-674-8720**.

## PRIOR AUTHORIZATION REQUEST INFORMATION

| | | |
|---|---|---|
| ☐ New request ☐ Renewal request | Total # of pages: | |
| Name of office contact: | Contact's phone number: | LTC facility contact/phone: |

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Patient name: | | Patient ID #: | DOB: |
| Street address: | | | |
| Apt #: | City/state/zip: | Phone: | |

## PRESCRIBER INFORMATION

| | | | |
|---|---|---|---|
| Prescriber name: | | | |
| Specialty: | | NPI: | State license #: |
| Street address: | | | |
| Suite #: | City/state/zip: | | |
| Phone: | | Fax: | |

## CLINICAL INFORMATION

**Medication requested:**

Preferred:

- ☐ Cholestyramine Powder
- ☐ Cholestyramine Powder Packet
- ☐ Cholestyramine Light Powder
- ☐ Cholestyramine Light Powder Packet
- ☐ Colestipol Tablet
- ☐ Ezetimibe Tablet
- ☐ Fenofibrate 54 mg Tablet (generic Lofibra Tablet)
- ☐ Fenofibrate 160 mg Tablet (generic Lofibra Tablet)
- ☐ Fenofibrate Micronized 43 mg Capsule (generic Antara)
- ☐ Fenofibrate Micronized 130 mg Capsule (generic Antara)
- ☐ Fenofibrate Micronized 67 mg Capsule (generic Lofibra Capsule)
- ☐ Fenofibrate Micronized 134 mg Capsule (generic Lofibra Capsule)
- ☐ Fenofibrate Micronized 200 mg Capsule (generic Lofibra Capsule)
- ☐ Fenofibrate Nanocrystalized 48 mg Tablet (generic Tricor)
- ☐ Fenofibrate Nanocrystalized 145 mg Tablet (generic Tricor)
- ☐ Fenofibric Acid (Choline) DR 45 mg Capsule (generic Trilipix)
- ☐ Fenofibric Acid (Choline) DR 135 mg Capsule (generic Trilipix)
- ☐ Gemfibrozil Tablet
- ☐ Nexletol Tablet
- ☐ Nexlizet Tablet
- ☐ Omega-3 Ethyl Esters Capsule (generic Lovaza)
- ☐ Praluent Pen
- ☐ Prevalite Powder
- ☐ Prevalite Powder Packet
- ☐ Repatha Sureclick

Non-Preferred:

- ☐ Antara Capsule
- ☐ Colesevelam Powder Packet
- ☐ Colesevelam Tablet
- ☐ Colestid Granule
- ☐ Colestid Tablet
- ☐ Colestipol Granule
- ☐ Colestipol Granule Packet
- ☐ Evkeeza Vial
- ☐ Fenofibrate 50 mg Capsule (generic Lipofen)
- ☐ Fenofibrate 150 mg Capsule (generic Lipofen)
- ☐ Fenofibrate 40 mg Tablet (generic Fenoglide)
- ☐ Fenofibrate 120 mg Tablet (generic Fenoglide)
- ☐ Fenofibrate (Micronized) 90 mg Capsule (generic Antara)
- ☐ Fenofibric Acid 35 mg Tablet (generic Fibricor)
- ☐ Fenofibric Acid 105 mg Tablet (generic Fibricor)
- ☐ Fenoglide Tablet
- ☐ Fibricor Tablet
- ☐ Icosapent Ethyl Capsule (generic Vascepa)
- ☐ Juxtapid Capsule
- ☐ Leqvio Syringe
- ☐ Lipofen Capsule
- ☐ Lopid Tablet
- ☐ Lovaza Capsule
- ☐ Niacin ER Tablet (generic Niaspan)
- ☐ Questran Powder
- ☐ Questran Powder Packet
- ☐ Questran Light Powder
- ☐ Tricor Tablet
- ☐ Trilipix DR Capsule
- ☐ Welchol Powder Packet
- ☐ Welchol Tablet
- ☐ Zetia Tablet

| | | |
|---|---|---|
| Dosage form: | | Strength: |
| Dose/directions: | Quantity: | Refills: |
| Diagnosis: | | Dx code *(required)*: |

## INITIAL REQUESTS

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

**1. For treatment of ANY LIPID DISORDER:**
- ☐ Has results of a lipid profile within the past 3 months (submit copy)

**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
    - ☐ List medications tried:_____
  - ☐ 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
      List medications tried:_____
    - ☐ 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
    Please explain:_____
- ☐ 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
    Please explain:_____
  - ☐ **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
    List medications tried:_____
- ☐ 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.)
    List medications tried:_____
- ☐ **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
- ☐ Has a diagnosis of homozygous familial hypercholesterolemia in accordance with current consensus guidelines
- ☐ One of the following:
  - ☐ Tried and failed or has a contraindication or an intolerance to PCSK9 inhibitors
    Please explain:_____
  - ☐ 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.)*
    List medications tried:_____
- ☐ 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
    List medications tried:_____
  - ☐ 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
    Please explain:_____

**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.)*
  List medications tried:_____

## 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.) (submit copy of results)
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.)*

   List medications tried:_____

## PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

| Prescriber signature: | Date: |
|---|---|