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

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

Prior authorization guidelines **Lipotropics, Other** and **Quantity Limits/Daily Dose Limits** are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.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:	
Member name:		City/state/zip:	
Member 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 member 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 member'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 member'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 member'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 member'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 844-205-3386

Prescriber Signature:	**Date**:

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)