

**LIPOTROPICS, OTHER PRIOR AUTHORIZATION FORM** (form effective 1/8/2024)

Prior authorization guidelines **Lipotropics, Other** and **Quantity Limits/Daily Dose Limits** are available on Geisinger Health Plan's website at <https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger>

<input type="checkbox"/> New request <input type="checkbox"/> 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 ( <u>submit documentation</u> ):		Dx code ( <u>required</u> ):	

**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):**

☐ Has at least one of the following **diagnoses**:

- ☐ A history of clinical atherosclerotic cardiovascular disease
- ☐ Familial hypercholesterolemia
- ☐ Severe hypercholesterolemia (baseline LDL-C  $\geq$ 190 mg/dL)

☐ 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 JXTAPID (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):

<input type="checkbox"/> age ≥50 years	<input type="checkbox"/> HDL-C ≤40 mg/dL for males or ≤50 mg/dL for females
<input type="checkbox"/> cigarette smoking	<input type="checkbox"/> retinopathy
<input type="checkbox"/> hypertension	<input type="checkbox"/> micro- or macroalbuminuria
<input type="checkbox"/> hs-CRP >3.00 mg/L	<input type="checkbox"/> ABI <0.9
<input type="checkbox"/> CrCl <60 mL/min	<input type="checkbox"/> 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 PCSK9 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 JXTAPID (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 submit to PromptPA <https://ghp.promptpa.com> OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.**

**Prescriber Signature:**

**Date:**

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