GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822
Tel. • 855•552•6028 PA Relay 711 GeisingerHealthPlan.com

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LIPOTROPICS, OTHER PRIOR AUTHORIZATION FORM *(form effective 1/9/2023)*

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

☐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:	
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):**
   ☐Has at least one of the following **diagnoses**:
   - ☐A history of clinical atherosclerotic cardiovascular disease
   - ☐Familial hypercholesterolemia
   - ☐Severe hypercholesterolemia (baseline LDL-C ≥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 doses of TWO different high-intensity statins (eg, atorvastatin, rosuvastatin) for at least THREE consecutive months each
   - ☐Is unable to tolerate high-intensity statins:
     - ☐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

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- ☐ 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
  - ☐ 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
- ☐ Is prescribed the PCKS9 inhibitor in addition to the maximally tolerated dose of the highest-tolerated intensity statin (if clinically appropriate)
- ☐ For a diagnosis of HoFH, is prescribed the PCKS9 inhibitor in addition to other standard lipid-lowering treatments
- ☐ **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):**
  - ☐ Is prescribed the medication by or in consultation with an appropriate specialist (eg, cardiologist, endocrinologist, other provider specializing in lipid disorders)
  - ☐ Tried and failed a PCSK9 inhibitor or has a contraindication or an intolerance to PCSK9 inhibitors
  - ☐ 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 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 medication in addition to other standard lipid-lowering treatments

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 *(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

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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):

☐ Is using the PCKS9 inhibitor in addition to the maximally tolerated dose of the highest-tolerated intensity statin

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

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

☐ Is prescribed the medication by or in consultation with an appropriate specialist (eg, cardiologist, endocrinologist, other provider specializing in lipid disorders)

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

☐ Is prescribed the 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**: