LIPOTROPICS, OTHER PRIOR AUTHORIZATION FORM *(form effective 1/5/2026)*

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):

☐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 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

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- ☐ 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
- ☐ Has results of genetic testing that are positive for mutations associated with lack of response to PCSK9 inhibitors

☐ 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.)

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☐ Has a contraindication to statins

5. For TRYNGOLZA (olezarsen):

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

☐ Has familial chylomicronemia syndrome (FCS) AND ONE of the following:

- ☐ Results of genetic testing showing biallelic pathogenic variations in FCS-causing genes
- ☐ A North American FCS score ≥60 (i.e., definite FCS)
- ☐ BOTH of the following:
  - ☐ A North American FCS score ≥45 and <60 (i.e., likely FCS)
  - ☐ An FCS score (Moulin score) ≥10 (i.e., FCS very likely)

6. 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**:

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.)