

Clinical Policy: Lipotropics, Other

Reference Number: PHW.PDL.055

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Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of PA Health & Wellness[®] that Other Lipotropics are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Lipotropics, Other

A. Prescriptions That Require Prior Authorization

Prescriptions for Lipotropics, Other that meet any of the following conditions must be prior authorized:

1. A non-preferred Lipotropic, Other.
2. A Lipotropic, Other with a prescribed quantity that exceeds the quantity limit.
3. A proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (e.g., Leqvio [inclisiran], Praluent [alirocumab], Repatha [evolocumab]).
4. An adenosine triphosphate-citrate lyase (ACL) inhibitor (e.g., Nexletol [bempedoic acid], Nexlizet [bempedoic acid/ezetimibe]).
5. A microsomal triglyceride transfer protein (MTP) inhibitor (e.g., Juxtapid [lomitapide]).
6. An angiopoietin-like 3 (ANGPTL3) inhibitor (e.g., Evkeeza [evinacumab]).
7. An apolipoprotein C-III (APOC-III)-directed Lipotropics, Other (e.g., Tryngolza [olezarsen], Redemplo [plozasiran]).

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Lipotropic, Other, the determination of whether the requested prescription is medically necessary will take into account whether the member:

1. Is prescribed the requested Lipotropic, Other for the treatment of a diagnosis that is consistent with the U.S. Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; AND
2. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; AND
3. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; AND
4. Does not have a contraindication to the prescribed drug; AND
5. For treatment of a lipid disorder, has documentation of results of a lipid profile within 3 months prior to the request for the Lipotropic, Other; AND
6. For a PCSK9 inhibitor, **all** of the following:
 - a. Has a history of **one** of the following:
 - i. Failure to achieve goal non-HDL-C, LDL-C, percentage reduction of LDL-C, or apoB while adherent to treatment with the maximally tolerated dose of a high-intensity statin for ≥ 3 months,
 - ii. **Both** of the following:
 - a) A temporally related intolerance¹ to a high-intensity statin that occurred after **both** of the following:
 - (i) Modifiable comorbid conditions that may enhance statin intolerance were ruled out and/or addressed by the prescriber as clinically indicated (e.g., hypothyroidism, vitamin D deficiency)
 - (ii) All possible drug interactions with statins were addressed if clinically appropriate (e.g., dose decrease or discontinuation of the interacting drug, change to an alternative statin that has a lower incidence of drug interactions)
 - b) **One** of the following:
 - (i) Therapeutic failure while adherent to treatment for ≥ 3 consecutive months-with the lowest FDA-approved daily dose or alternate-day dosing of any statin
 - (ii) A temporally related intolerance to the lowest FDA-approved daily dose or alternate-day dosing of any statin,

¹ Temporally related intolerance of a statin is defined as the occurrence of symptoms and/or lab abnormalities upon initiation of a statin, resolution of symptoms and/or lab abnormalities upon discontinuation of a statin, and recurrence of symptoms and/or lab abnormalities after rechallenge with the same statin at the same dose.

- iii. A contraindication to statins,
- b. Has **one** of the following:
 - i. A history of therapeutic failure of while adherent to treatment with ezetimibe in combination with the maximally tolerated dose of the highest-tolerated intensity statin (if clinically appropriate) for ≥ 3 consecutive months,
 - ii. A contraindication or an intolerance to ezetimibe,
 - iii. 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 (if clinically appropriate) for ≥ 3 consecutive months,
- c. Is prescribed the requested PCSK9 inhibitor in addition to **one** of the following:
 - i. For treatment of homozygous familial hypercholesterolemia (HoFH), standard lipid-lowering treatments as recommended by current consensus guidelines²
 - ii. For treatment of all other conditions, the maximally tolerated dose of the highest-tolerated intensity statin (if clinically appropriate),
- d. If currently using a different PCSK9 inhibitor, will discontinue use of that PCSK9 inhibitor prior to starting the requested PCSK9 inhibitor,
- e. For a non-preferred PCSK9 inhibitor, has **one** of the following:
 - i. A history of therapeutic failure of at least 1 preferred PCSK9 inhibitor approved or medically accepted for the member's diagnosis
 - ii. A contraindication or an intolerance to the preferred PCSK9 inhibitors approved or medically accepted for the member's diagnosis;

AND

- 7. For an ACL inhibitor, **all** of the following:
 - a. Has a history of **one** of the following:
 - i. Failure to achieve goal non-HDL-C, LDL-C percentage reduction of LDL-C, or apoB while adherent to treatment with the maximally tolerated dose of a high-intensity statin for ≥ 3 months,
 - ii. **Both** of the following:

² e.g., American Heart Association/American College of Cardiology, American Association of Clinical Endocrinologists/American College of Endocrinology, American Diabetes Association, National Lipid Association, European Society of Cardiology/European Atherosclerosis Society, International Familial Hypercholesterolaemia Foundation, International Atherosclerosis Society

- a) A temporally related intolerance to a high-intensity statin that occurred after **both** of the following:
 - (i) Modifiable comorbid conditions that may enhance statin intolerance were ruled out and/or addressed by the prescriber as clinically indicated (e.g., hypothyroidism, vitamin D deficiency)
 - (ii) All possible drug interactions with statins were addressed if clinically appropriate (e.g., dose decrease or discontinuation of the interacting drug, change to an alternative statin that has a lower incidence of drug interactions)
 - b) **One** of the following:
 - (i) Therapeutic failure while adherent to treatment for ≥ 3 consecutive months with the lowest FDA-approved daily dose or alternate-day dosing of any statin
 - (ii) A temporally related intolerance to the lowest FDA-approved daily dose or alternate-day dosing of any statin,
 - iii. A contraindication to statins,
- b. Has **one** of the following:
- i. A history of therapeutic failure of while adherent to treatment with ezetimibe in combination with the maximally tolerated dose of the highest-tolerated intensity statin (if clinically appropriate) for ≥ 3 consecutive months
 - ii. A contraindication or an intolerance to ezetimibe,
- c. Is prescribed the requested ACL inhibitor in addition to the maximally tolerated dose of the highest-tolerated intensity statin (if clinically appropriate),
- d. If currently taking simvastatin or pravastatin, will not be using the requested ACL inhibitor concomitantly with simvastatin at a dose of >20 mg daily or pravastatin at a dose of >40 mg daily;

AND

8. For an ANGPTL3 inhibitor or MTP inhibitor, **all** of the following:
- a. Is prescribed the requested drug by or in consultation with a cardiologist, endocrinologist, or other provider specializing in lipid disorders,
 - b. For treatment of HoFH, has a diagnosis of HoFH in accordance with current consensus guidelines,
 - c. **One** of the following:

- i. Has a history of therapeutic failure of or a contraindication or an intolerance to PCSK9 inhibitors
 - ii. Has results of genetic testing that are positive for mutations associated with lack of response to PCSK9 inhibitors
- d. Is prescribed the requested drug in addition to standard lipid-lowering treatments as recommended by current consensus guidelines;

AND

9. For icosapent ethyl, **all** of the following:

- a. Has fasting triglycerides greater than or equal to 150 mg/dL,
- b. **One** of the following:
 - i. Has a history of clinical atherosclerotic cardiovascular disease (ASCVD),
 - ii. **Both** of the following:
 - a) Has diabetes mellitus
 - b) Has at least one additional ASCVD risk factors (e.g., age ≥ 50 years, cigarette smoking or stopped smoking within 3 months, hypertension or on antihypertensive medication, HDL-C ≤ 40 mg/dL for males or ≤ 50 mg/dL for females, hs-CRP > 3.00 mg/L, CrCl > 30 mL/min and < 60 mL/min, retinopathy, micro- or macroalbuminuria, ABI < 0.9),
 - iii. Has a history of therapeutic failure of or a contraindication or an intolerance to a preferred fibric acid derivative Lipotropics, Other approved or medically accepted for the member's diagnosis,
- c. Has **one** of the following:
 - i. A history of therapeutic failure of while adherent to treatment with the maximum tolerated dose of a statin for ≥ 3 consecutive months,
 - ii. A history of statin intolerance after modifiable risk factors have been addressed,
 - iii. A contraindication to statins;

AND

10. For an *apoC-III*-directed Lipotropics, Other, **all** of the following:

- a. Is prescribed the requested drug by or in consultation with a cardiologist, endocrinologist, gastroenterologist, or other provider specializing in lipid disorders

- b. **One** of the following:
 - i. For treatment of familial chylomicronemia syndrome (FCS), has **both** of the following:
 - a) Untreated fasting triglycerides ≥ 880 mg/dL
 - b) One of the following:
 - (i) Results of genetic testing showing biallelic pathogenic variants in FCS-causing genes,
 - (ii) A North American FCS (NAFCS) score greater than or equal to 60 (i.e., definite FCS),
 - (iii) **Both** of the following:
 - a. An NAFCS score greater than or equal to 45 and less than 60 (i.e., likely FCS)
 - b. An FCS score (Moulin score) greater than or equal to 10 (i.e., FCS very likely)
 - ii. For all other diagnoses, both of the following:
 - a) Has a diagnosis that is confirmed according to applicable consensus guidelines,
 - b) Has a history of therapeutic failure of or a contraindication or an intolerance to first line therapy(ies) if applicable according to consensus treatment guidelines;
 - c. If currently using a different apoC-III-directed Lipotropics, Other, will discontinue use of that apoC-III-directed Lipotropics, Other prior to starting the requested apoC-III-directed Lipotropics, Other,
 - d. For Tryngolza (olezarsen), has a history of therapeutic failure of or a contraindication or an intolerance to Redemplo (plozasiran) if Redemplo (plozasiran) is approved or medically accepted for the member's diagnosis;
- 11. For all other non-preferred Lipotropics, Other, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Lipotropics, Other approved or medically accepted for the member's diagnosis; AND
- 12. If a prescription for a Lipotropic, Other is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override

NOTE: If the member does not meet the clinical review guidelines but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR LIPOTROPICS, OTHER: The determination of medical necessity of a request for renewal of a prior authorization for a Lipotropic, Other that was previously approved will take into account whether the member:

1. Has documentation of a positive clinical response since starting the requested drug (e.g., decreased LDL-C, decreased triglycerides, fewer episodes of acute pancreatitis, etc.); **AND**
2. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
3. Does not have a contraindication to the prescribed drug; **AND**
4. For a PCSK9 inhibitor, both of the following:
 - a. Is using the requested PCSK9 inhibitor in addition to **one** of the following:
 - i. For treatment of HoFH, standard lipid-lowering treatments as recommended by current consensus guidelines³
 - ii. For treatment of all other conditions, the maximally tolerated dose of the highest-tolerated intensity statin (if clinically appropriate);
 - b. For a non-preferred PCSK9 inhibitor, has one of the following:
 - i. A history of therapeutic failure of at least one preferred PCSK9 inhibitor approved or medically accepted for the member's diagnosis
 - ii. A contraindication or an intolerance to the preferred PCSK9 inhibitors approved or medically accepted for the member's diagnosis;

AND

5. For an ACL inhibitor, **both** of the following:
 - a. Is using the requested ACL inhibitor in addition to the maximally tolerated dose of the highest-tolerated intensity statin (if clinically appropriate)
 - b. If currently taking simvastatin or pravastatin, is not using the requested ACL inhibitor concomitantly with simvastatin at a dose of >20 mg daily or pravastatin at a dose of >40 mg daily;

AND

6. For an ANGPTL3 inhibitor or MTP inhibitor, **both** of the following:

³ e.g., American Heart Association/American College of Cardiology, American Association of Clinical Endocrinologists/American College of Endocrinology, American Diabetes Association, National Lipid Association, European Society of Cardiology/European Atherosclerosis Society, International Familial Hypercholesterolaemia Foundation, International Atherosclerosis Society

- a. Is prescribed the requested drug by or in consultation with a cardiologist, endocrinologist, or other provider specializing in lipid disorders
- b. Is using the requested drug in addition to standard lipid-lowering treatments as recommended by current consensus guidelines;

AND

7. For icosapent ethyl, experienced a decrease in fasting triglycerides since starting icosapent ethyl; AND
8. For an *apoC-III*-directed Lipotropic, Other, both of the following:
 - a. Is prescribed the requested drug by or in consultation with a cardiologist, endocrinologist, gastroenterologist, or other provider specializing in lipid disorders,
 - b. For Tryngolza (olezarsen), has a history of therapeutic failure of or a contraindication or an intolerance to Redemplo (plozasiran) if Redemplo (plozasiran) is approved or medically accepted for the member's diagnosis;
9. For all other non-preferred Lipotropics, Other, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Lipotropics, Other approved or medically accepted for the member's diagnosis; AND
10. If a prescription for a Lipotropic, Other is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

NOTE: If the member does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a Lipotropic, Other. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member.

D. Dose and Duration of Therapy

Initial requests will be approved for up to 6 months.

Renewal requests will be approved for up to 12 months.

E. References

1. Patel SB, Belalcazar LM, Afreen S, et al. American Association of Clinical Endocrinology consensus statement: algorithm for management of adults with dyslipidemia – 2025 update. Endocrine Practice. 2025;31:1207-1238.
2. Blumenthal RS, Morris PB, Gaudino M, et al. 2026 ACC/AHA/AACVPR/ABC/ACPM/ADA/AGS/AphA/ASPC/NLA/PCNA guideline on the management of dyslipidemia: a report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Circulation. 2026;153:e00-e00.

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021: policy revised according to DHS revisions effective 01/05/2021.	11/2020
Q1 2022: policy revised according to DHS revisions effective 01/03/2022.	10/2021
Q1 2023: policy revised according to DHS revisions effective 01/09/2023.	10/2022
Q1 2024: policy revised according to DHS revisions effective 01/08/2024.	11/2023
Q1 2025: policy revised according to DHS revisions effective 01/06/2025.	11/2024
Q1 2026: policy revised according to DHS revisions effective 01/05/2026.	11/2025
Q3 2026: policy revised according to DHS revisions effective 07/06/2026.	07/2026