Clinical Policy: Lipotropics, Statins

Reference Number: PHW.PDL.063
Effective Date: 01/01/2020
Last Review Date: 11/2025

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 Lipotropic, Statin are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Lipotropic, Statins

A. Prescriptions That Require Prior Authorization

Prescriptions for a Lipotropic, Statin that meets any of the following conditions must be prior authorized:

1. A non-preferred Lipotropic, Statin.

2. A Lipotropic, Statin with a prescribed quantity that exceeds the quantity limit.

3. A Lipotropic, Statin when there is a record of a recent paid claim for another Lipotropic, Statin (therapeutic duplication)

B. Review of Documentation for Medical Necessity

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

1. For a non-preferred Lipotropic, Statin, **one** of the following:
   a. For a non-preferred Lipotropics, Statin that contains only one active ingredient, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Lipotropics, Statins
   b. For a non-preferred Lipotropics, Statin combination product that contains more than one active ingredient (e.g., amlodipine-atorvastatin, ezetimibe-simvastatin), has a clinical reason as documented by the prescriber why the individual active ingredients cannot be used concurrently;

AND

2. For therapeutic duplication, **one** of the following:

   a. The being transitioned to or from another Lipotropic, Statin with the intent of discontinuing one of the drugs;

b. Has a medical reason for concomitant use of the requested drugs that is supported by peer-reviewed medical literature or national treatment guidelines;

AND

3. If a prescription for a Lipotropic, Statin is in 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 the request for a prescription for a non-preferred Lipotropic, Statin. If the applicable guideline in Section B is met, the reviewer will prior authorize the prescription. If the applicable guideline is 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 recipient.

D. **Approval Duration: 12 months**

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