Jefferson Health Plans

MEDICAID / CHIP

PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Lipotropics - Other

Phone: 866-841-7659 **Fax back to: 866-240-3712**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:	
Member ID Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Phone Number:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. What is the product being requested?

- ☐ PCSK9 inhibitor
- ☐ ACL inhibitor
- ☐ ANGPTL3 inhibitor or MTP inhibitor
- ☐ Icosapent ethyl
- ☐ apoC-III-directed Lipotropics, Other
- ☐ Lipotropics, Other
- ☐ Other

Q2. If other, please specify:

Q3. Is the member prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q4. Does the member have a contraindication to the prescribed drug?

☐ No ☐ Yes

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Q5. Is this an initial request or re-authorization request?

☐ Initial request ☐ Reauthorization request

Q6. Does the member have documentation of a positive clinical response since starting the requested drug (e.g., decreased LDL-C, decreased triglycerides, fewer episodes of acute pancreatitis, etc.)?

☐ Yes ☐ No

Q7. For a PCSK9 inhibitor, is the member prescribed the requested PCSK9 inhibitor in addition to one of the following?

☐ For treatment of homozygous familial hypercholesterolemia (HoFH), standard lipid-lowering treatments as recommended by current consensus guidelines

☐ For treatment of all other conditions, the maximum tolerated dose of the highest-tolerated intensity statin (if clinically appropriate)

☐ None of the above

Q8. Is the request for a preferred PCSK9 inhibitor?

☐ Yes ☐ No

Q9. For a non-preferred PCSK9 inhibitor, does the member have one of the following?

☐ A history of therapeutic failure of at least one preferred PCSK9 inhibitor approved or medically accepted for the beneficiary's diagnosis

☐ A contraindication or an intolerance to the preferred PCSK9 inhibitors approved or medically accepted for the beneficiary's diagnosis

☐ None of the above

Q10. For an ACL inhibitor, does the member meet both of the following?

☐ Is using the requested ACL inhibitor in addition to the maximum tolerated dose of the highest-tolerated intensity statin (if clinically appropriate)

☐ If currently taking simvastatin or pravastatin, is not using the requested ACL inhibitor concomitantly with simvastatin at a dose of greater than 20 mg daily or pravastatin at a dose of greater than 40 mg daily

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☐ None of the above

Q11. For an ANGPTL3 inhibitor or MTP inhibitor, does the member meet both of the following:

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

☐ The member using the requested drug in addition to standard lipid-lowering treatments as recommended by current consensus guidelines

☐ None of the above

Q12. For icosapent ethyl, has the member experienced a decrease in fasting triglycerides since starting icosapent ethyl?

☐ Yes ☐ No

Q13. For apoC-III-directed Lipotropics, Other, does the member meet both of the following:

☐ Prescribed the requested drug by or in consultation with a cardiologist, endocrinologist, gastroenterologist, or other provider specializing in lipid disorders

☐ For Tryngolza (olezarsen), does the member have 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 beneficiary's diagnosis?

☐ None of the above

Q14. For all other non-preferred Lipotropics, Other, does the member have a history of therapeutic failure of or a contraindication or an intolerance to the preferred Lipotropics, Other approved or medically accepted for the beneficiary's diagnosis?

☐ Yes ☐ No

Q15. Is the member prescribed the requested Lipotropics, 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?

☐ Yes ☐ No

Q16. Is the member age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

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☐ Yes ☐ No

Q17. For treatment of a lipid disorder, does the member have documentation of results of a lipid profile within three months prior to the request for the Lipotropics, Other?

☐ Yes ☐ NA ☐ No

Q18. For a PCSK9 inhibitor and an ACL inhibitor, does the member have a history of failure to achieve goal non-HDL-C, LDL-C, percentage reduction of LDL-C, or apoB while adherent to treatment with the maximum tolerated dose of a high-intensity statin for greater than or equal to three months?

☐ Yes ☐ No ☐ NA

Q19. Does the member have a contraindication to statins?

☐ Yes ☐ No

Q20. Does the member have a history of a temporally related intolerance to a high-intensity statin that occurred after both of the following:

☐ 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)

☐ 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)

☐ None of the above

Q21. Does the member have one of the following?

☐ Therapeutic failure while adherent to treatment for greater than or equal to three consecutive months with the lowest FDA-approved daily dose or alternate-day dosing of any statin

☐ A temporally related intolerance to the lowest FDA-approved daily dose or alternate-day dosing of any statin

☐ None of the above

Q22. Is the request for a PCSK9 inhibitor?

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☐ Yes ☐ No

Q23. For the diagnosis Lipotropics, Other, does the member have one of the following?

☐ A history of therapeutic failure of while adherent to treatment with ezetimibe in combination with the maximum tolerated dose of the highest-tolerated intensity statin (if clinically appropriate) for greater than or equal to three consecutive months

☐ A contraindication or an intolerance to ezetimibe

☐ An LDL-C that is greater than 25% above goal LDL-C while adherent to treatment with the maximum tolerated dose of the highest-tolerated intensity statin (if clinically appropriate) for greater than or equal to three consecutive months

☐ None of the above

Q24. Is the member using the requested PCSK9 inhibitor in addition to one of the following?

☐ For treatment of homozygous familial hypercholesterolemia (HoFH), standard lipid-lowering treatments as recommended by current consensus guidelines

☐ For treatment of all other conditions, the maximum tolerated dose of the highest-tolerated intensity statin (if clinically appropriate)

☐ None of the above

Q25. If currently using a different PCSK9 inhibitor, will the member discontinue use of that PCSK9 inhibitor prior to starting the requested PCSK9 inhibitor?

☐ Yes ☐ No

Q26. For a non-preferred PCSK9 inhibitor, does the member have one of the following?

☐ A history of therapeutic failure of at least one preferred PCSK9 inhibitor approved or medically accepted for the beneficiary's diagnosis

☐ A contraindication or an intolerance to the preferred PCSK9 inhibitors approved or medically accepted for the beneficiary's diagnosis

☐ None of the above

Q27. For an ACL inhibitor, does the member have a history of one of the following?

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☐ A history of therapeutic failure of while adherent to treatment with ezetimibe in combination with the maximum tolerated dose of the highest-tolerated intensity statin (if clinically appropriate) for greater than or equal to three consecutive months

☐ A contraindication or an intolerance to ezetimibe

☐ None of the above

Q28. Is the member prescribed the requested ACL inhibitor in addition to the maximum tolerated dose of the highest-tolerated intensity statin (if clinically appropriate)?

☐ Yes ☐ No

Q29. If currently taking simvastatin or pravastatin, will the member not be using the requested ACL inhibitor concomitantly with simvastatin at a dose of greater than 20 mg daily or pravastatin at a dose of greater than 40 mg daily?

☐ Yes ☐ No

Q30. For an ANGPTL3 inhibitor or MTP inhibitor, is the member prescribed the requested drug by or in consultation with a cardiologist, endocrinologist, or other provider specializing in lipid disorders?

☐ Yes ☐ No

Q31. For treatment of HoFH, does the member have a diagnosis of HoFH in accordance with current consensus guidelines?

☐ Yes ☐ No

Q32. For the diagnosis Lipotropics, Other, does the member have one of the following?

☐ A history of therapeutic failure of or a contraindication or an intolerance to PCSK9 inhibitors

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

☐ None of the above

Q33. Is the member prescribed the requested drug in addition to standard lipid-lowering treatments as recommended by current consensus guidelines?

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☐ Yes ☐ No

Q34. For the diagnosis Lipotropics, Other, does the member have one of the following?

☐ A history of therapeutic failure of or a contraindication or an intolerance to PCSK9 inhibitors

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

☐ None of the above

Q35. Is the member prescribed the requested drug in addition to standard lipid-lowering treatments as recommended by current consensus guidelines?

☐ Yes ☐ No

Q36. For icosapent ethyl, does the member have fasting triglycerides greater than or equal to 150 mg/dL?

☐ Yes ☐ No

Q37. For the diagnosis Lipotropics, Other, does the member have one of the following?

☐ A history of clinical atherosclerotic cardiovascular disease (ASCVD)

☐ Both of the following: Has diabetes mellitus AND Has at least one additional ASCVD risk factor (e.g., 50 years of age or older, cigarette smoking or stopped smoking within three months, hypertension or on antihypertensive medication, HDL-C less than or equal to 40 mg/dL for males or 50 mg/dL for females, hs-CRP greater than 3.0 mg/L, CrCl greater than 30 mL/min and less than 60 mL/min, retinopathy, micro- or macroalbuminuria, ABI less than 0.9)

☐ 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 beneficiary's diagnosis

☐ None of the above

Q38. For the diagnosis Lipotropics, Other, does the member have one of the following?

☐ A history of therapeutic failure of while adherent to treatment with the maximum tolerated dose of a statin for greater than or equal to three consecutive months

☐ A history of statin intolerance after modifiable risk factors have been addressed

☐ A contraindication to statins

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☐ None of the above

Q39. For apoC-III-directed Lipotropics, Other, is the member prescribed the requested drug by or in consultation with a cardiologist, endocrinologist, gastroenterologist, or other provider specializing in lipid disorders?

☐ Yes ☐ No

Q40. For treatment of familial chylomicronemia syndrome (FCS), does the member have untreated fasting triglycerides greater than or equal to 880 mg/dL?

☐ Yes ☐ NA ☐ No

Q41. Does the member have results of genetic testing showing biallelic pathogenic variants in FCS-causing genes?

☐ Yes ☐ No

Q42. Does the member have a North American FCS (NAFCS) score greater than or equal to 60 (i.e., definite FCS)?

☐ Yes ☐ No

Q43. Does the member meet both of the following:

☐ An NAFCS score greater than or equal to 45 and less than 60 (i.e., likely FCS)
☐ An FCS score (Moulin score) greater than or equal to 10 (i.e., FCS very likely)
☐ None of the above

Q44. For all other diagnoses, both of the following:

☐ Has a diagnosis that is confirmed according to applicable consensus guidelines
☐ 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
☐ None of the above

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Q45. If currently using a different apoC-III-directed Lipotropics, Other, will the member discontinue use of that apoC-III-directed Lipotropics, Other prior to starting the requested apoC-III-directed Lipotropics, Other?

☐ Yes ☐ NA ☐ No

Q46. For Tryngolza (olezarsen), does the member have 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 beneficiary's diagnosis?

☐ Yes ☐ No

Q47. For all other non-preferred Lipotropics, Other, does the member have a history of therapeutic failure of or a contraindication or an intolerance to the preferred Lipotropics, Other approved or medically accepted for the beneficiary's diagnosis?

☐ Yes ☐ No

Q48. Additional Information:

Prescriber Signature

Date

v2026-06