



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: <input type="checkbox"/> Medicaid <input type="checkbox"/> 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. The request is for a Lipotropics, Other that was previously approved. If YES, go to 37.

Yes

No

Q2. The member meets ALL of the following:

Is prescribed the requested Lipotropics, Other for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication

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

Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

Does not have a contraindication to the prescribed drug

Q3. For treatment of a lipid disorder, has documentation of results of a lipid profile within three months prior to the request for the Lipotropics, Other.

Yes

No

Q4. What type of drug is being requested?

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<input type="checkbox"/> For a PCSK9 inhibitor, go to 5. <input type="checkbox"/> For an ACL inhibitor, go to 15. <input type="checkbox"/> For a ANGPTL3 inhibitor or MTP inhibitor, go to 23. <input type="checkbox"/> For a icosapent ethyl, go to 11. <input type="checkbox"/> For an APOC-III-directed ASO, go to 28. <input type="checkbox"/> For all other non-preferred Lipotropics, Other go to 36.
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<p>Q5. For a PCSK9 inhibitor, the member has a history of failure to achieve goal LDL-C or percentage reduction of LDL-C while adherent to treatment with the maximum tolerated dose of a high-intensity statin for greater than or equal to three months.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<p>Q6. For a PCSK9 inhibitor, the member has a history of a temporally related intolerance to two high-intensity statins that occurred after 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).</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<p>Q7. For a PCSK9 inhibitor, the member has a history of a temporally related intolerance to two high-intensity statins that occurred after all possible drug interactions with statins were addressed by all of the following (if clinically appropriate):</p> <p><input type="checkbox"/> Dose decrease of the interacting non-statin drug, <input type="checkbox"/> Discontinuation of the interacting non-statin drug, <input type="checkbox"/> Change to an alternative statin that has a lower incidence of drug interactions</p>
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<p>Q8. The member had 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.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<p>Q9. The member had a temporally related intolerance to the lowest FDA-approved daily dose or alternate-day dosing of any statin.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Q10. The member has a contraindication to statins

Yes No

Q11. The member has 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

Q12. Is 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)

Q13. If currently using a different PCSK9 inhibitor, will discontinue use of that PCSK9 inhibitor prior to starting the requested PCSK9 inhibitor.

Yes No

Q14. The request is for a non-preferred PCSK9 inhibitor and the member has 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.

Q15. For an ACL inhibitor, has a history of failure to achieve goal LDL-C or percentage reduction of LDL-C while adherent to treatment with the maximum tolerated dose of a high-intensity statin for greater than or equal to three months.

Yes No

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Q16. For an ACL inhibitor, has a history of a temporally related intolerance to two high-intensity statins that occurred after 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).

- Yes No

Q17. Has a history of a temporally related intolerance to two high-intensity statins that occurred after all possible drug interactions with statins were addressed by all of the following (if clinically appropriate):

- Dose decrease of the interacting non-statin drug
- Discontinuation of the interacting non-statin drug
- Change to an alternative statin that has a lower incidence of drug interactions

Q18. The member meets 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

Q19. The member has a contraindication to statins.

- Yes No

Q20. The member has 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

Q21. The member is prescribed the requested ACL inhibitor in addition to the maximum tolerated dose of the highest-tolerated intensity statin (if clinically appropriate).

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<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Q22. If currently taking simvastatin or pravastatin, the member will 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.

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Q23. For an ANGPTL3 inhibitor or MTP inhibitor, is prescribed the requested drug by or in consultation with a cardiologist, endocrinologist, or other provider specializing in lipid disorders.

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Q24. For treatment of HoFH, has a diagnosis of HoFH in accordance with current consensus guidelines.

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Q25. The member meets ONE of the following:

<input type="checkbox"/> Has a history of therapeutic failure of or a contraindication or an intolerance to PCSK9 inhibitors	<input type="checkbox"/> Has results of genetic testing that are positive for mutations associated with lack of response to PCSK9 inhibitors
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Q26. The member is prescribed the requested drug in addition to standard lipid-lowering treatments as recommended by current consensus guidelines.

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Q27. For icosapent ethyl, the member has a history of clinical ASCVD.

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Q28. The member meets BOTH of the following:

<input type="checkbox"/> Has diabetes mellitus	<input type="checkbox"/> Has two additional ASCVD risk factors (e.g., 50 years of age or older, cigarette smoking, hypertension, HDL-C less than or equal to 40 mg/dL for males or 50 mg/dL for
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females, hs-CRP greater than 3.00 mg/L, CrCl less than 60 mL/min, retinopathy, micro- or macroalbuminuria, ABI less than 0.9]).

Q29. The member has 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

Q30. The member has fasting triglycerides greater than or equal to 150 mg/dL.

Yes

No

Q31. The member has ONE of the following:

- A history of therapeutic failure of while adherent to treatment with maximum tolerated doses of two different statins for greater than or equal to three consecutive months each
- A history of statin intolerance after modifiable risk factors have been addressed
- A contraindication to statins

Q32. For an APOC-III-directed ASO, the member is prescribed the requested drug by or in consultation with a cardiologist, endocrinologist, gastroenterologist, or other provider specializing in lipid disorders.

Yes

No

Q33. For treatment of familial chylomicronemia syndrome (FCS), has ONE of the following:

- Results of genetic testing showing biallelic pathogenic variants in FCS-causing genes
- A North American FCS (NAFCS) score greater than or equal to 60 (i.e., definite FCS)

Q34. The member meets 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).

Q35. For all other diagnoses, the member 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.

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<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Q36. For all other non-preferred Lipotropics, Other, the member has 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

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Q37. Documentation is attached showing a positive clinical response since starting the requested drug (e.g., decreased LDL-C, decreased triglycerides, fewer episodes of acute pancreatitis, etc.).

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Q38. The member is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Q39. The member does not have a contraindication to the prescribed drug.

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Q40. What type of drug is being requested?

- For a PCSK9 inhibitor, go to 41.
- For an ACL inhibitor, go to 42.
- For an ANGPTL3 inhibitor or MTP inhibitor, go to 43
- For an icosapent ethyl, go to 44.
- For an APOC-III-directed ASO, go to 45.
- For all other non-preferred Lipotropics, go to 46.

Q41. For a PCSK9 inhibitor, is using the requested PCSK9 inhibitor in addition to ONE of the following:

<input type="checkbox"/> For treatment of HoFH, standard lipid-lowering treatments as recommended by current consensus guidelines	<input type="checkbox"/> For treatment of all other conditions, the maximum tolerated dose of the highest-tolerated intensity statin (if clinically appropriate)
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Q42. For an ACL inhibitor, both of the following:

<input type="checkbox"/> Is using the requested ACL inhibitor in addition to the maximum tolerated dose of the highest-tolerated intensity statin (if clinically appropriate)	<input type="checkbox"/> 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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Q43. For an ANGPTL3 inhibitor or MTP inhibitor, both of the following:

<input type="checkbox"/> Is prescribed the requested drug by or in consultation with a cardiologist, endocrinologist, or other provider specializing in lipid disorders	<input type="checkbox"/> Is using the requested drug in addition to standard lipid-lowering treatments as recommended by current consensus guidelines
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Q44. For icosapent ethyl, experienced a decrease in fasting triglycerides since starting icosapent ethyl

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Q45. For an APOC-III-directed ASO, is prescribed the requested drug by or in consultation with a cardiologist, endocrinologist, gastroenterologist, or other provider specializing in lipid disorders.

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Q46. 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 beneficiary's diagnosis.

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Q47. Additional Information:

Prescriber Signature

Date