



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

Prior authorization guidelines **Lipotropics, Other** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	Total pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			NPI:	State license #:
LTC facility contact/phone:			Street address:	
Beneficiary name:			City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:	
Dose/directions:		Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):		Dx code (<i>required</i>):	

Complete all sections that apply to the beneficiary 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 \geq 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
 - 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 beneficiary'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*):

<input type="checkbox"/> age ≥50 years	<input type="checkbox"/> HDL-C ≤40 mg/dL for males or ≤50 mg/dL for females
<input type="checkbox"/> cigarette smoking	<input type="checkbox"/> retinopathy
<input type="checkbox"/> hypertension	<input type="checkbox"/> micro- or macroalbuminuria
<input type="checkbox"/> hs-CRP >3.00 mg/L	<input type="checkbox"/> ABI <0.9
<input type="checkbox"/> CrCl <60 mL/min	<input type="checkbox"/> 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 beneficiary'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.)

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 beneficiary'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 PCSK9 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 JXTAPID (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 beneficiary'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 DHS – PHARMACY DIVISION

Prescriber Signature:

Date:

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