Health Partners
A part of Jefferson Health Plans

HEALTH PARTNERS PLANS
2024 PRIOR AUTHORIZATION REQUEST FORM

Lipotropics - Other

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners 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.

Patient Name:	Prescriber Name:	
HPP HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient Primary Phone:	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:**	

HPP's maximum approval time is 12 months but may be less depending on the drug.

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. Is the request for renewal of prior authorization for a drug that has been previously approved? If yes, go to Q39. If no, go to Q2.

☐ Yes ☐ No

Q2. Is the requested drug prescribed for the treatment of a diagnosis that is indicated in the Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

☐ Yes ☐ No

Q3. Is the requested drug prescribed with a dose that is consistent with the Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q4. Is the requested drug age-appropriate according to the Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

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Q5. Does the patient have a history of a contraindication to the requested drug?

☐ Yes ☐ No

Q6. For the treatment of a lipid disorder, does the patient have documentation of results of a lipid profile within 3 months prior to the request for the lipotropic - other?

☐ Yes ☐ No

Q7. Is the requested drug a (PCSK9) inhibitor?

☐ Yes ☐ No

Q8. Does the patient have one of the following?
a. A history of clinical atherosclerotic cardiovascular disease (ASCVD),
b. A diagnosis of familial hypercholesterolemia in accordance with current guidelines,
c. A diagnosis of other severe hypercholesterolemia (baseline [before treatment with any lipid-lowering agent] low density lipoprotein cholesterol [LDL-C] greater than or equal to 190 milligrams per deciliter)

☐ Yes ☐ No

Q9. Does the patient have a history of therapeutic failure while adherent to treatment with the maximally tolerated dose of a high-intensity statin for greater than or equal to 3 months?

☐ Yes ☐ No

Q10. Does the patient have a contraindication to statins?

☐ Yes ☐ No

Q11. Did the patient have a temporally related intolerance to 2 high-intensity statins that occurred after both of the following?
a. 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);
b. all possible drug interactions with statins were addressed by all of the following (if clinically appropriate):
1. dose decrease of the interacting non-statin drug;
2. discontinuation of the interacting non-statin drug;
3. AND change to an alternative statin that has a lower incidence of drug interactions?

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☐ Yes ☐ No

Q12. Does the patient have one of the following?
A) a therapeutic failure while adherent to treatment for greater than or equal to 3 consecutive months with the lowest approved daily dose or alternate-day dosing of any statin
B) OR a temporally related intolerance to the lowest approved daily dose or alternative-day dosing of any statin

☐ Yes ☐ No

Q13. Does the patient have a history of one of the following?
A) a therapeutic failure while adherent to treatment with ezetimibe in combination with the maximally tolerated dose of the highest-tolerated intensity statin (if clinically appropriate) for greater than or equal to 3 consecutive months
B) a contraindication or intolerance to ezetimibe.
C) An LDL-C that is greater than 25% above goal LDL-C while adherent to treatment with the maximally tolerated dose of the highest-tolerated intensity statin for greater than or equal to 3 consecutive months.

☐ Yes ☐ No

Q14. For PCSK9 Inhibitor one of the following?
A) For the treatment of homozygous familial hypercholesterolemia (HoFH) is the requested drug being used with standard lipid-lowering treatments as recommended by current consensus guidelines?
B) For treatment of all other conditions, is the requested drug being used with the maximally tolerated dose of the highest tolerated intensity statin (if clinically appropriate)?

☐ Yes ☐ No

Q15. If the patient is currently using a different PCSK9 inhibitor, will they discontinue use of that PCSK9 inhibitor prior to starting the requested PCSK9 inhibitor?

☐ Yes ☐ No

Q16. Is the requested drug a non-preferred (PCSK9) inhibitor?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q17. Does the patient have a documented history of therapeutic failure, contraindication, or intolerance to at least 1 preferred (PCSK9) inhibitor(s) approved or medically accepted for the patient's diagnosis OR a contraindication or an intolerance to the preferred PCSK9 inhibitors approved or medically accepted for the patient's diagnosis?

☐ Yes ☐ No

Q18. Is the request for an ACL inhibitor?

☐ Yes ☐ No

Q19. Does the patient have one of the following:
A) a diagnosis of familial hypercholesterolemia in accordance with current guidelines, OR
B) a history of clinical (ASCVD), OR
C) a diagnosis of other severe hypercholesterolemia (baseline [before treatment with any lipid-lowering agent] LDL-C ≥190 mg/dL)?

☐ Yes ☐ No

Q20. Does the patient have a history of therapeutic failure while adherent to treatment with the maximally tolerated dose a high-intensity statin for greater than or equal to 3 months?

☐ Yes ☐ No

Q21. Does the patient have a contraindication to statins?

☐ Yes ☐ No

Q22. Did the patient have a temporally related intolerance to 2 high-intensity statins that occurred after both of the following?

A) 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);

B) All possible drug interactions with statins were addressed by all of the following (if clinically appropriate):
1. dose decrease of the interacting non-statin drug,
2. discontinuation of the interacting non-statin drug,
3. AND change to an alternative statin that has a lower incidence of drug interactions?)

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Patient Name:	Prescriber Name:

☐ Yes ☐ No

Q23. Did the patient experience therapeutic failure while adherent to treatment for greater than or equal to 3 consecutive months with the lowest FDA-approved daily dose or alternate-day dosing of any statin?

☐ Yes ☐ No

Q24. Did the patient have a temporally related intolerance to the lowest FDA-approved daily dose or alternative-day dosing of any statin?

☐ Yes ☐ No

Q25. Does the patient have a history of one of the following?
A) therapeutic failure while adherent to treatment with ezetimibe in combination with the maximally tolerated dose of the highest-tolerated intensity statin (if clinically appropriate) for greater than or equal to 3 consecutive months; OR
B) a contraindication or intolerance to ezetimibe?

☐ Yes ☐ No

Q26. Is the ACL inhibitor being used with the maximally tolerated dose of the highest-tolerated intensity statin (if clinically appropriate)?

☐ Yes ☐ No

Q27. If currently taking simvastatin or pravastatin, will the requested ACL inhibitor concomitantly be used with simvastatin at a dose of greater than 20 mg daily or pravastatin at a dose greater than 40 mg daily?

☐ Yes ☐ No

Q28. Is the requested drug an ANGPTL3 inhibitor or MTP inhibitor?

☐ Yes ☐ No

Q29. Is the drug prescribed by or in consultation with an appropriate specialist (e.g. cardiologist, endocrinologist, or other provider specializing in lipid disorders)?

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Patient Name:	Prescriber Name:

☐ Yes ☐ No

Q30. Is the requested drug being used to treat homozygous familial hypercholesterolemia (HoFH)?

☐ Yes ☐ No

Q31. Does the patient have a history of therapeutic failure, contraindication, or intolerance to (PCSK9) inhibitors?

☐ Yes ☐ No

Q32. Is the patient homozygous for LDL receptor (LDLR)-negative mutations (i.e., has LDLR-negative mutations inboth alleles) associated with LDLR activity below 2%?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q34. Is the request for icosapent ethyl?

☐ Yes ☐ No

Q35. Does the patient have one of the following?
A) a history of clinical ASCVD,
B) a diagnosis of diabetes mellitus OR 2 additional ASCVD risk factors,
C) a history of therapeutic failure of or a contraindication or an intolerance to the preferred Lipotropics?

☐ Yes ☐ No

Q36. Does the patient have a fasting triglycerides level of greater than or equal to 150 mg/dL?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q37. Does the patient have one of the following?
A) A history of therapeutic failure of while adherent to treatment with maximally tolerated doses of 2 different statins for ≥3 consecutive months each,
B) A history of statin intolerance after modifiable risk factors have been addressed OR
C) A contraindication to statins?

☐ Yes ☐ No

Q38. For all other non-preferred Lipotropics - Other, does the patient have a history of therapeutic failure, contraindication, or intolerance to the preferred drugs under this class approved or medically accepted for the patient's diagnosis?

☐ Yes ☐ No

Q39. For RENEWALS: Does the patient have documentation of a positive clinical response demonstrated by lab test results, if appropriate for the diagnosis, since starting the requested medication (e.g., decreased low-density lipoprotein cholesterol [LDL-C], decreased triglycerides, etc.)?

☐ Yes ☐ No

Q40. Is the dose of the requested drug consistent with the Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q41. Does the patient have a contraindication to the requested drug?

☐ Yes ☐ No

Q42. For a (PCSK9) inhibitor is the patient using the requested PCSK9 inhibitor in addition to one of the following?

A) For the treatment of HoFH along with standard lipid- lowering treatments OR

B) For the treatment of all other conditions with the maximally tolerated dose of the highest-tolerated intensity statin

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q43. Is the renewal request for an ACL inhibitor?

☐ Yes ☐ No

Q44. Is the ACL inhibitor being used with the maximally tolerated dose of the highest-tolerated intensity statin (if clinically appropriate)?

☐ Yes ☐ No

Q45. If currently taking simvastatin or pravastatin, Is the ACL inhibitor being used concomitantly with simvastatin at a dose of greater than 20 mg daily or pravastatin at a dose of 40 mg daily?

☐ Yes ☐ No

Q46. Is the renewal request for an ANGPTL3 inhibitor or MTP inhibitor?

☐ Yes ☐ No

Q47. Is the MTP inhibitor prescribed by or in consultation with a cardiologist, endocrinologist, or other provider specializing in lipid disorders?

☐ Yes ☐ No

Q48. Is the patient using the ANGPTL3 inhibitor or MTP inhibitor in addition to standard lipid-lowering treatments as recommended by current consensus guidelines?

☐ Yes ☐ No

Q49. Is the renewal request for icosapent ethyl?

☐ Yes ☐ No

Q50. Did the patient experience a decrease in fasting triglycerides since starting icosapent ethyl?

☐ Yes ☐ No

Q51. For all other non-preferred Lipotropics - Other, does the patient 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?

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Patient Name:	Prescriber Name:

☐ Yes	☐ No
Q52. Additional Information:	

Prescriber Signature _____ Date _____

Updated for 2024

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