Health Partners Plans

HEALTH PARTNERS PLANS
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 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?

☐ 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

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 proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor?

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☐ Yes ☐ No

Q8. Does the patient have one of the following (i.e., primary prevention): A) a diagnosis of familial hypercholesterolemia in accordance with current guidelines, OR B) a diagnosis of other severe primary 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 clinical atherosclerotic cardiovascular disease (ASCVD) (i.e., secondary prevention)?

☐ Yes ☐ No

Q10. Does the patient have a history of therapeutic failure while adherent to treatment with the maximally tolerated dose of 2 different high-intensity statins for greater than or equal to 3 consecutive months each?

☐ Yes ☐ No

Q11. Does the patient have a contraindication to statins?

☐ Yes ☐ No

Q12. 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, AND 3) change to an alternative statin that has a lower incidence of drug interactions?

☐ Yes ☐ No

Q13. Did the patient experience 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?

☐ Yes ☐ No

Q14. Did the patient have a temporally related intolerance to the lowest approved daily dose or alternative-day dosing of any statin?

☐ Yes ☐ No

Q15. Does the patient have a history of 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?

☐ Yes ☐ No

Q16. Does the patient have a contraindication or intolerance to ezetimibe?

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☐ Yes	☐ No
Q17. Is the drug being used to treat homozygous familial hypercholesterolemia?	
☐ Yes	☐ No
Q18. Is the requested drug being used with standard lipid-lowering treatments as recommended by current consensus guidelines for the treatment of homozygous familial hypercholesterolemia (HoFH)?	
☐ Yes	☐ No
Q19. Is the requested drug being used with the maximally tolerated dose of the highest-tolerated intensity statin (if clinically appropriate)?	
☐ Yes	☐ No
Q20. 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
Q21. Is the requested drug a non-preferred proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor?	
☐ Yes	☐ No
Q22. Does the patient have a documented history of therapeutic failure, contraindication, or intolerance to the preferred proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor(s) approved or medically accepted for the patient's diagnosis?	
☐ Yes	☐ No
Q23. Is the requested drug an MTP inhibitor?	
☐ Yes	☐ No
Q24. Is the MTP inhibitor prescribed by or in consultation with a cardiologist, endocrinologist, or other provider specializing in lipid disorders?	
☐ Yes	☐ No
Q25. Is the requested drug being used to treat homozygous familial hypercholesterolemia (HoFH)?	
☐ Yes	☐ No
Q26. Has the diagnosis of homozygous familial hypercholesterolemia (HoFH) been made in accordance with current consensus guidelines?	
☐ Yes	☐ No
Q27. Does the patient have a history of therapeutic failure, contraindication, or intolerance of proprotein convertase	

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subtilisin/kexin type 9 (PCSK9) inhibitors?

☐ Yes ☐ No

Q28. Is the patient homozygous for low-density lipoprotein receptor (LDLR)-negative mutations (i.e., has LDLR-negative mutations in both alleles) associated with LDLR activity below 2 percent?

☐ Yes ☐ No

Q29. Will be using the MTP inhibitor in addition to standard lipid-lowering treatments as recommended by current consensus guidelines?

☐ Yes ☐ No

Q30. Is the request for an ACL inhibitor?

☐ Yes ☐ No

Q31. 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 atherosclerotic cardiovascular disease (ASCVD)?

☐ Yes ☐ No

Q32. Does the patient have a history of therapeutic failure while adherent to treatment with the maximally tolerated dose of 2 different high-intensity statins for greater than or equal to 3 consecutive months each?

☐ Yes ☐ No

Q33. Does the patient have a contraindication to statins?

☐ Yes ☐ No

Q34. 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, AND 3) change to an alternative statin that has a lower incidence of drug interactions?)?

☐ Yes ☐ No

Q35. 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

Q36. Did the patient have a temporally related intolerance to the lowest FDA-approved daily dose or alternative-day dosing of any statin?

☐ Yes ☐ No

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Q37. 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

Q38. Is the ACL inhibitor being used with the maximally tolerated dose of the highest-tolerated intensity statin (if clinically appropriate)?

☐ Yes ☐ No

Q39. 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

Q40. 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

Q41. Is the request for an ANGPTL3 inhibitor?

☐ Yes ☐ No

Q42. Is the ANGPTL3 inhibitor being prescribed by or in consultation with a cardiologist, endocrinologist, or other provider specializing in lipid disorders?

☐ Yes ☐ No

Q43. Is the ANGPTL3 inhibitor being used For treatment of HoFH, has a diagnosis of HoFH in accordance with current consensus guidelines?

☐ Yes ☐ No

Q44. Does the patient have one of the following: a) A history of therapeutic failure of or a contraindication or an intolerance to PCSK9 inhibitors; b) Is homozygous for LDLR-negative mutations (i.e., has LDLR-negative mutations in both alleles) associated with LDLR activity below 2%?

☐ Yes ☐ No

Q45. Will the patient be using the ANGPTL3 inhibitor in addition to standard lipid-lowering treatments as recommended by current consensus guidelines?

☐ Yes ☐ No

Q46. Does the patient have documentation of tolerability and 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

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Q47. 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

Q48. Does the patient have a contraindication to the requested drug?

☐ Yes ☐ No

Q49. Is the requested drug a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor?

☐ Yes ☐ No

Q50. Is the requested drug being used for treatment of homozygous familial hypercholesterolemia (HoFH)?

☐ Yes ☐ No

Q51. Is the requested PCSK9 inhibitor being used in addition to standard lipid-lowering treatments for the treatment of Homozygous Familial Hypercholesterolemia (HoFH) as recommended by current consensus guidelines?

☐ Yes ☐ No

Q52. Is the requested PCSK9 inhibitor being used in addition to the maximally tolerated dose of the highest-tolerated intensity statin for all other conditions?

☐ Yes ☐ No

Q53. Is the requested drug an MTP inhibitor?

☐ Yes ☐ No

Q54. Is the MTP inhibitor prescribed by or in consultation with a cardiologist, endocrinologist, or other provider specializing in lipid disorders?

☐ Yes ☐ No

Q55. Is the patient be using the MTP inhibitorin addition to standard lipid-lowering treatments as recommended by current consensus guidelines?

☐ Yes ☐ No

Q56. Is the request for an ACL inhibitor?

☐ Yes ☐ No

Q57. Is the ACL inhibitor being used with the maximally tolerated dose of the highest-tolerated intensity statin (if clinically appropriate)?

☐ Yes ☐ No

Q58. If currently taking simvastatin or pravastatin, Is the ACL inhibitor being used concomitantly with simvastatin at a

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dose of greater than 20 mg daily or pravastatin at a dose of 40 mg daily?

☐ Yes ☐ No

Q59. Is the request for an ANGPTL3 inhibitor?

☐ Yes ☐ No

Q60. Is the ANGPTL3 inhibitor prescribed by or in consultation with a cardiologist, endocrinologist, or other provider specializing in lipid disorders?

☐ Yes ☐ No

Q61. Will the ANGPTL3 inhibitor be used in addition to standard lipid-lowering treatments as recommended by current consensus guidelines?

☐ Yes ☐ No

Q62. 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?

☐ Yes ☐ No

Q63. Requested Duration:

☐ 12 Months

Q64. Additional Information:

Prescriber Signature

Date

Updated for 2022