



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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.

Form with fields: Patient Name, Prescriber Name, HPP Member Number, Date of Birth, Patient Primary Phone, Address, City, State ZIP, Line of Business, Drug Name, Quantity, Directions, Diagnosis Code, Diagnosis, etc.

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 (PCSK9) inhibitor?



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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:

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 2 different high-intensity statins for greater than or equal to 3 consecutive months each?

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

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
OR B) 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



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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:

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 checkbox

No checkbox

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 checkbox

No checkbox

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

Yes checkbox

No checkbox

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 checkbox

No checkbox

Q18. Is the request for an ACL inhibitor?

Yes checkbox

No checkbox

Q19. Is the ACL inhibitor prescribed by or in consultation with an appropriate specialist (e.g. cardiologist, endocrinologist, or other provider specializing in lipid disorders)?

Yes checkbox

No checkbox

Q20. 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 checkbox

No checkbox

Q21. 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 checkbox

No checkbox

Q22. Does the patient have a contraindication to statins?

Yes checkbox

No checkbox



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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:

Q23. 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

Q24. 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

Q25. Did the patient have a temporally related intolerance to the lowest FDA-approved daily dose or alternative-day dosing of any statin?

Yes No

Q26. 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 OR
C) 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 (if clinically appropriate) for =3 consecutive months

Yes No

Q27. Does the patient have one of the following?

- A) A history of therapeutic failure of while adherent to treatment with a PCSK9 inhibitor OR
B) A contraindication or an intolerance to PCSK9 inhibitors

Yes No

Q28. Is the ACL inhibitor being used with the maximally tolerated dose of the highest-tolerated intensity statin (if clinically appropriate)?

Yes No

Q29. 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

Q30. Is the requested drug an ANGPTL3 inhibitor or MTP inhibitor?



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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:

Form containing 10 questions (Q31-Q40) with checkboxes for Yes/No. Questions cover topics like specialist consultation, HoFH, therapeutic failure, LDLR mutations, and statin adherence.



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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:

Q40. 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?
Q41. 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.)?
Q42. 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?
Q43. Does the patient have a contraindication to the requested drug?
Q44. For a (PCSK9) inhibitor is the patient using the requested PCSK9 inhibitor in addition to one of the following?
Q45. Is the renewal request for an ACL inhibitor?
Q46. Is the ACL inhibitor prescribed by or in consultation with a cardiologist, endocrinologist, or other provider specializing in lipid disorders?
Q47. Is the ACL inhibitor being used with the maximally tolerated dose of the highest-tolerated intensity statin (if clinically appropriate)?
Q48. 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?
Q49. Is the renewal request for an ANGPTL3 inhibitor or MTP inhibitor?



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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:

Q50. Is the MTP inhibitor prescribed by or in consultation with a cardiologist, endocrinologist, or other provider specializing in lipid disorders?
Q51. Is the patient be using the ANGPTL3 inhibitor or MTP inhibitor in addition to standard lipid-lowering treatments as recommended by current consensus guidelines?
Q52. Is the renewal request for icosapent ethyl?
Q53. Did the patient experience a decrease in fasting triglycerides since starting icosapent ethyl?
Q54. 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?
Q55. Additional Information:

Prescriber Signature

Date

Updated for 2023