

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



Fax to PerformRxSM at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774**.

PRIOR AUTHORIZATION REQUEST INFORMATION			
<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		Total # of pages:	
Name of office contact:		Contact's phone number:	LTC facility contact/phone:
PATIENT INFORMATION			
Patient name:		Patient ID #:	DOB:
Street address:			
Apt #:	City/state/zip:		Phone:
PRESCRIBER INFORMATION			
Prescriber name:			
Specialty:		NPI:	State license #:
Street address:			
Suite #:	City/state/zip:		
Phone:		Fax:	
CLINICAL INFORMATION			
Medication requested:			
Preferred:		Non-Preferred:	
<input type="checkbox"/> Cholestyramine Powder <input type="checkbox"/> Cholestyramine Powder Packet <input type="checkbox"/> Cholestyramine Light Powder <input type="checkbox"/> Cholestyramine Light Powder Packet <input type="checkbox"/> Colestipol Tablet <input type="checkbox"/> Ezetimibe Tablet <input type="checkbox"/> Fenofibrate 54 mg Tablet (generic Lofibra Tablet) <input type="checkbox"/> Fenofibrate 160 mg Tablet (generic Lofibra Tablet) <input type="checkbox"/> Fenofibrate Micronized 43 mg Capsule (generic Antara) <input type="checkbox"/> Fenofibrate Micronized 130 mg Capsule (generic Antara) <input type="checkbox"/> Fenofibrate Micronized 67 mg Capsule (generic Lofibra Capsule) <input type="checkbox"/> Fenofibrate Micronized 134 mg Capsule (generic Lofibra Capsule) <input type="checkbox"/> Fenofibrate Micronized 200 mg Capsule (generic Lofibra Capsule) <input type="checkbox"/> Fenofibrate Nanocrystalized 48 mg Tablet (generic Tricor)	<input type="checkbox"/> Fenofibrate Nanocrystalized 145 mg Tablet (generic Tricor) <input type="checkbox"/> Fenofibric Acid (Choline) DR 45 mg Capsule (generic Trilipix) <input type="checkbox"/> Fenofibric Acid (Choline) DR 135 mg Capsule (generic Trilipix) <input type="checkbox"/> Gemfibrozil Tablet <input type="checkbox"/> Nexletol Tablet <input type="checkbox"/> Nexlizet Tablet <input type="checkbox"/> Omega-3 Ethyl Esters Capsule (generic Lovaza) <input type="checkbox"/> Praluent Pen <input type="checkbox"/> Prevalite Powder <input type="checkbox"/> Prevalite Powder Packet <input type="checkbox"/> Repatha Pushtronex <input type="checkbox"/> Repatha Sureclick <input type="checkbox"/> Repatha Syringe	<input type="checkbox"/> Colesevelam Powder Packet <input type="checkbox"/> Colesevelam Tablet <input type="checkbox"/> Colestid Granule <input type="checkbox"/> Colestid Tablet <input type="checkbox"/> Colestipol Granule <input type="checkbox"/> Colestipol Granule Packet <input type="checkbox"/> Evkeeza Vial <input type="checkbox"/> Fenofibrate 50 mg Capsule (generic Lipofen) <input type="checkbox"/> Fenofibrate 150 mg Capsule (generic Lipofen) <input type="checkbox"/> Fenofibrate 40 mg Tablet (generic Fenoglide) <input type="checkbox"/> Fenofibrate 120 mg Tablet (generic Fenoglide) <input type="checkbox"/> Fenofibrate (Micronized) 90 mg Capsule (generic Antara) <input type="checkbox"/> Fenofibric Acid 35 mg Tablet (generic Fibracor)	<input type="checkbox"/> Fenofibric Acid 105 mg Tablet (generic Fibracor) <input type="checkbox"/> Icosapent Ethyl Capsule (generic Vascepa) <input type="checkbox"/> Juxtapid Capsule <input type="checkbox"/> Leqvio Syringe <input type="checkbox"/> Lipofen Capsule <input type="checkbox"/> Lopid Tablet <input type="checkbox"/> Lovaza Capsule <input type="checkbox"/> Niacin ER Tablet (generic Niaspan) <input type="checkbox"/> Questran Powder <input type="checkbox"/> Questran Powder Packet <input type="checkbox"/> Questran Light Powder <input type="checkbox"/> Tricor Tablet <input type="checkbox"/> Tryngolza Autoinjector <input type="checkbox"/> Welchol Powder Packet <input type="checkbox"/> Welchol Tablet <input type="checkbox"/> Zetia Tablet
Dosage form:		Strength:	
Dose/directions:		Quantity:	Refills:
Diagnosis:		Dx code <i>(required)</i> :	

INITIAL REQUESTS

**Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.**

1. For treatment of ANY LIPID DISORDER:

- Has results of a lipid profile within the past 3 months (submit copy)

2. For a PCSK9 INHIBITOR (eg, Leqvio, Praluent, Repatha), NEXLETOL (bempedoic acid), or NEXLIZET (bempedoic acid/ezetimibe):

- 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
 - List medications tried: _____
 - 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
 - List medications tried: _____
 - 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
 - Please explain: _____
- 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
 - Please explain: _____
 - 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
 - List medications tried: _____
- 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.)
 - List medications tried: _____
- 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 JXTAPID (lomitapide):

- Is prescribed the requested medication by or in consultation with a cardiologist, endocrinologist, or other provider specializing in lipid disorders
- Has a diagnosis of homozygous familial hypercholesterolemia in accordance with current consensus guidelines
- One of the following:
 - Tried and failed or has a contraindication or an intolerance to PCSK9 inhibitors
 - Please explain: _____
 - 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):
 - age ≥50 years
 - cigarette smoking
 - hypertension
 - hs-CRP >3.00 mg/L
 - CrCl <60 mL/min
 - HDL-C ≤40 mg/dL for males or ≤50 mg/dL for females
 - retinopathy
 - micro- or macroalbuminuria
 - ABI <0.9
 - 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.)
 - List medications tried: _____
- 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
 - List medications tried: _____
 - 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
 - Please explain: _____

INITIAL REQUESTS

**Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.**

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
- 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 score greater than or equal to 45 (i.e., definite FCS or likely FCS)
 - An FCS score greater than or equal to 10 (i.e., FCS very likely)
- For all other diagnoses, has one of the following:
 - Has tried and failed first line therapy(ies) recommended by consensus treatment guidelines
 - Has a contraindication or an intolerance to first line therapy(ies) recommended by consensus treatment guidelines

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.)
- List medications tried: _____

RENEWAL REQUESTS

1. For ALL diagnoses:

- Experienced a positive clinical response since starting the requested medication
(e.g., decreased LDL-C, decreased triglycerides, fewer episodes of acute pancreatitis, etc.) (submit copy of results and/or chart notes)

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 JUXTAPID (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 TRYNGOLZA (olezarsen):

- Is prescribed the requested medication by or in consultation with a cardiologist, endocrinologist, gastroenterologist or other provider specializing in lipid disorders

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.)
- List medications tried: _____

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature: _____	Date: _____
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