iowa total care | Iowa Health Link Iowa HHS | Hawki Iowa HHS

Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization

Apolipoprotein C-III (ApoC-III) Inhibitors

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
	Pharmacy fax	

Prior authorization (PA) is required for apoC-III inhibitors. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and

2. Patient has a diagnosis of familial chylomicronemia syndrome (FCS) confirmed by genetic testing, (e.g., biallelic pathogenic variants in FCS-causing genes [*LPL, GPIHBP1, APOA5, APOC2*, or *LMF1*]) (attach genetic testing results); and

3. The patient has a current fasting triglyceride level of 880 mg/dL or greater (attach current lipid panel obtained within the past 30 days); and

4. The patient will use medication in combination with a low-fat diet (≤ 20 grams of total fat per day); and

5. Medication will not be used concomitantly with other apoC-III inhibitors; and

6. Is prescribed by or in consultation with a cardiologist, an endocrinologist, or a provider who specializes in lipid management.

If the criteria for coverage are met, initial requests will be given for 12 months. Requests for continuation of therapy will be considered at 12-month intervals under the following conditions:

1. **Documentation of a decrease in fasting triglyceride level from baseline (attach current lipid panel obtained within the past 30 days); and**
2. **Patient continues to use medication in combination with a low-fat diet (≤ 20 grams of total fat per day); and**
3. **Is prescribed by or in consultation with a cardiologist, an endocrinologist, or a provider who specializes in lipid management.**

Non-Preferred

☐ Tryngolza

Strength	Usage Instructions	Quantity	Day's Supply
____________	____________________________	____________	______________

Diagnosis (attach genetic testing results):____

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Current Fasting triglyceride level: ______________________

Date obtained (attach current lipid panel obtained within the past 30 days): ____________

Will patient use medication in combination with a low-fat diet (≤ 20 grams of total fat per day)?

☐ Yes ☐ No

Will medication be used concomitantly with other apoC-III inhibitors?

☐ Yes ☐ No

Is prescriber a cardiologist, an endocrinologist, or a provider who specializes in lipid management?

❑ **Yes, document specialty:** ____

❑ **No** If no, note consultation with specialist:

Consultation Date:_________ Physician Name, Specialty & Phone: ________________________________

Renewal Requests

Document a decrease in fasting triglyceride level from baseline (attach current lipid panel obtained within the past 30 days).

Current fasting triglyceride level: ______________________ Date obtained: _______________

Is patient continuing to use medication in combination with a low-fat diet (≤ 20 grams of total fat per day)?

☐ Yes ☐ No

Is prescriber a cardiologist, an endocrinologist, or a provider who specializes in lipid management?

❑ **Yes, document specialty:** ____

❑ **No** If no, note consultation with specialist:
Consultation Date:_________Physician Name, Specialty & Phone: ________________________________

Medical or contraindication reason to override trial requirements:_____________________________________

____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization, the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*