**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
# ADENOSINE TRIPHOSPHATE-CITRATE LYASE 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 NPI | Pharmacy fax | NDC |

**Prior authorization (PA) is required for adenosine triphosphate-citrate lyase (ACL) inhibitors. Payment will be considered under the following conditions:**

1. **Patient meets the FDA approved age; and**
2. **Documentation of adherence to prescribed lipid lowering medications (including a maximally tolerated statin), prior to ACL inhibitor therapy, for the previous 90 days is provided (further defined below, by diagnosis); and**
3. **Documentation is provided that medication will be used in combination with a maximally tolerated statin; and**
4. **A baseline and current lipid profile is provided. Baseline lipid profile is defined as a lipid profile obtained prior to pharmacologic therapy; and**
5. **Patient will continue to follow an appropriate low fat diet; and**
6. **Is prescribed by or in consultation with a lipidologist, cardiologist, or endocrinologist; and**
7. **If patient is taking in combination with:**
    a. **Simvastatin, dose does not exceed 20mg per day; or**
    b. **Pravastatin, dose does not exceed 40mg per day; and**
8. **Concurrent use with a PCSK9 inhibitor will not be considered; and**
9. **Goal is defined as a 50% reduction in untreated baseline LDL-C; and**
10. **Is prescribed for one of the following diagnoses:**
    a. **Heterozygous Familial Hypercholesterolemia (HeFH):**
        i. **Documentation is provided verifying diagnosis (attach documentation/results), as evidenced by:**
            1. **Clinical manifestations of HeFH (e.g. tendon xanthomas, cutaneous xanthomas, arcus cornea, tuberous xanthomas, or xantehlasma): or**
            2. **Confirmation of diagnosis by gene or receptor testing: and**
        ii. **Documentation of untreated LDL-C ≥ 190 mg/dL: and**
        iii. **Patient is unable to reach LDL-C goal with a minimum of two separate, chemically distinct statin trials used in combination with other lipid lowering medications. Trials are defined as: concurrent use of a maximally tolerated dose of a statin (must include atorvastatin and rosuvastatin), PLUS ezetimibe 10mg daily; or**
    b. **Clinical Atherosclerotic Cardiovascular Disease (ASCVD):**
        i. **History of MI, angina, coronary or other arterial revascularization, stroke, TIA, or PVD of atherosclerotic origin; and**
        ii. **Patient is unable to reach LDL-C goal with a minimum of two separate, chemically distinct statin**

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**trials used in combination with other lipid lowering medications. Trials are defined as: concurrent use of a maximally tolerated dose of a statin (must include atorvastatin and rosuvastatin), PLUS ezetimibe 10mg daily.**

**If criteria for coverage are met, requests will be approved for 3 months. Additional authorizations will be considered at yearly intervals under the following conditions:**

a. **Patient continues therapy with a maximally tolerated statin dose and remains at goal; and**
b. **Patient continues to follow an appropriate low fat diet; and**
c. **Documentation of LDL reduction is provided.**

**The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.**

**Non-Preferred**

☐ Nexletol ☐ Nexlizet

| Strength | Dosage Instructions | Quantity | Days Supply |
|---|---|---|---|
| | | | |

**Diagnosis:** _____

**Attach baseline lipid profile (obtained prior to pharmacologic therapy)**

**Has patient been adherent to prescribed lipid lowering medications for the previous 90 days?**

☐ Yes ☐ No

**Will ACL inhibitor be used in combination with a maximally tolerated statin?**

☐ Yes (document statin below) ☐ No

Concurrent Statin: Name/Dose:_____ Start Date: _____

**Will patient continue to follow an appropriate low fat diet?** ☐ Yes ☐ No

**Will ACL inhibitor be used in combination with a PCSK9 inhibitor?** ☐ Yes ☐ No

**Is prescriber a lipidologist, cardiologist, or endocrinologist?**

☐ Yes ☐ No (If no, note consultation with lipidologist, cardiologist, or endocrinologist)

Consultation Date: _____

Physician Name, Phone & Specialty: _____

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**Trials:**

Statin Trial 1: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

Statin Trial 2: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

Ezetimibe Trial: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

☐ **Heterozygous Familial Hypercholesterolemia (HeFH):**

**Attach documentation of one of the following:**
- Clinical manifestations of HeFH (e.g. tendon xanthomas, cutaneous xanthomas, arcus cornea, tuberous xanthomas, or xanthelasma)
- Confirmation of diagnosis by gene or receptor testing

☐ **Clinical Atherosclerotic Cardiovascular Disease (ASCVD):**

**Does patient have history of any of the following:**
- MI
- Angina
- Coronary or other arterial revascularization
- Stroke
- TIA
- PVD of atherosclerotic origin

☐ **Renewals:**

**Is patient continuing therapy with a maximally tolerated statin and at goal?** ☐ Yes ☐ No

**Is patient currently following an appropriate low fat diet?** ☐ Yes ☐ No

**Current LDL (attach documentation): _____ Date obtained: _____**

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 Human Services, that the member continues to be eligible for Medicaid.*