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

Fax to PerformRx[SM] at **1-855-851-4058**, or to speak to a representative call **1-888-674-8720**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ 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:

- ☐ Cholestyramine Powder
- ☐ Cholestyramine Powder Packet
- ☐ Cholestyramine Light Powder
- ☐ Cholestyramine Light Powder Packet
- ☐ Colestipol Tablet
- ☐ Ezetimibe Tablet
- ☐ Fenofibrate 54 mg Tablet (generic Lofibra Tablet)
- ☐ Fenofibrate 160 mg Tablet (generic Lofibra Tablet)
- ☐ Fenofibrate Micronized 43 mg Capsule (generic Antara)
- ☐ Fenofibrate Micronized 130 mg Capsule (generic Antara)
- ☐ Fenofibrate Micronized 67 mg Capsule (generic Lofibra Capsule)
- ☐ Fenofibrate Micronized 134 mg Capsule (generic Lofibra Capsule)
- ☐ Fenofibrate Micronized 200 mg Capsule (generic Lofibra Capsule)
- ☐ Fenofibrate Nanocrystalized 48 mg Tablet (generic Tricor)
- ☐ Fenofibrate Nanocrystalized 145 mg Tablet (generic Tricor)
- ☐ Fenofibric Acid (Choline) DR 45 mg Capsule (generic Trilipix)
- ☐ Fenofibric Acid (Choline) DR 135 mg Capsule (generic Trilipix)
- ☐ Gemfibrozil Tablet
- ☐ Nexletol Tablet
- ☐ Nexlizet Tablet
- ☐ Omega-3 Ethyl Esters Capsule (generic Lovaza)
- ☐ Praluent Pen
- ☐ Prevalite Powder
- ☐ Prevalite Powder Packet
- ☐ Repatha Pushtronex
- ☐ Repatha Sureclick
- ☐ Repatha Syringe

Non-Preferred:

- ☐ Colesevelam Powder Packet
- ☐ Colesevelam Tablet
- ☐ Colestid Granule
- ☐ Colestid Tablet
- ☐ Colestipol Granule
- ☐ Colestipol Granule Packet
- ☐ Evkeeza Vial
- ☐ Fenofibrate 50 mg Capsule (generic Lipofen)
- ☐ Fenofibrate 150 mg Capsule (generic Lipofen)
- ☐ Fenofibrate 40 mg Tablet (generic Fenoglide)
- ☐ Fenofibrate 120 mg Tablet (generic Fenoglide)
- ☐ Fenofibrate (Micronized) 90 mg Capsule (generic Antara)
- ☐ Fenofibric Acid 35 mg Tablet (generic Fibricor)
- ☐ Fenofibric Acid 105 mg Tablet (generic Fibricor)
- ☐ Icosapent Ethyl Capsule (generic Vascepa)
- ☐ Juxtapid Capsule
- ☐ Leqvio Syringe
- ☐ Lipofen Capsule
- ☐ Lopid Tablet
- ☐ Lovaza Capsule
- ☐ Niacin ER Tablet (generic Niaspan)
- ☐ Questran Powder
- ☐ Questran Powder Packet
- ☐ Questran Light Powder
- ☐ Tricor Tablet
- ☐ Tryngolza Autoinjector
- ☐ Welchol Powder Packet
- ☐ Welchol Tablet
- ☐ Zetia Tablet

Dosage form:		Strength:
Dose/directions:	Quantity:	Refills:
Diagnosis:		Dx code *(required)*:

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 JUXTAPID (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 PCKS9 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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