



Request for Prior Authorization
ADENOSINE TRIPHOSPHATE-CITRATE LYASE INHIBITORS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, 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...
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...
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...
ii. Documentation of untreated LDL-C ≥ 190 mg/dL: and
iii. Patient is unable to reach LDL-C goal...
b. Clinical Atherosclerotic Cardiovascular Disease (ASCVD):
i. History of MI, angina, coronary or other arterial revascularization, stroke, TIA, or PVD...
ii. Patient is unable to reach LDL-C goal...

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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
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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.