IOWA Health and Human Services

Request for Prior Authorization
ADENOSINE TRIPHOSPHATE-CITRATE LYASE INHIBITORS

FAX Completed Form To
1 (800) 574-2515
Provider Help Desk
1 (877) 776-1567

(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. **Request adheres to all FDA approved labeling for requested drug and indication(s), including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and**
2. **A baseline and current lipid profile is provided. Baseline lipid profile is defined as a lipid profile obtained prior to lipid lowering medication therapy; and**
3. **Patient will continue to follow an appropriate low-fat diet; and**
4. **Patient has one of the following diagnoses:**
   - **a. Heterozygous familial hypercholesterolemia (HeFH); or**
   - **b. Primary hyperlipidemia; or**
   - **c. Established cardiovascular disease (CVD) (e.g. previous myocardial infarction, history of an acute coronary syndrome, angina, previous stroke or transient ischemic attack, coronary artery disease, peripheral arterial disease, coronary or other arterial revascularization); or**
   - **d. At risk for CVD event but without established CVD (e.g. diabetes mellitus (type 1 or 2), a Reynolds Risk score > 20% or a SCORE Risk score > 7.5% over 10 years, a coronary artery calcium score > 300 Agatston units); and**
5. **Meets one of the following:**
   - **a. Patient must be adherent to lipid lowering medication therapy and is unable to reach LDL-C goal with a minimum of two separate, chemically distinct statin trials, including atorvastatin and rosuvastatin, at maximally tolerated doses, used in combination with ezetimibe for a minimum of 90 consecutive days; or**
   - **b. Patient is statin intolerant as documented by an inability to tolerate at least two chemically distinct statins; or**
   - **c. Patient has an FDA labeled contraindication to all statins; and**
6. **Goal is defined as a 50% reduction in untreated baseline LDL-C; and**
7. **Concurrent use with a PCSK9 inhibitor will not be considered.**

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:

1. **Patient continues with lipid lowering therapy at a maximally tolerated dose; or**
2. **Patient is intolerant to or has a contraindication to statins; and**
3. **Patient continues to follow an appropriate low-fat diet; and**
4. **Documentation of a positive response to therapy (e.g., LDL-C reduction).**

The required trials may be overridden when documented evidence is provided that the 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 lipid lowering medication therapy) and current lipid profile (after treatment with lipid lowering medication)

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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

Diagnosis:

☐ **Heterozygous Familial Hypercholesterolemia (HeFH)**

☐ **Primary hyperlipidemia**

☐ **Established cardiovascular disease (CVD): Document CVD: _____**

☐ **At risk for CVD but without established CVD: Document CVD Risk: _____**

Meets one of the following:

☐ **Patient is adherent to lipid lowering medication therapy and is unable to reach LDL-C goal with a minimum of two separate chemically distinct statin trials, including atorvastatin and rosuvastatin, at maximally tolerated doses, used in combination with ezetimibe for a minimum of 90 consecutive days**

Trials:

Atorvastatin Trial: Name/Dose: _____ Trial Dates:_____

Failure reason:_____

Rosuvastatin Trial: Name/Dose: _____ Trial Dates:_____

Failure reason:_____

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

Failure reason:_____

☐ **Patient is statin intolerant as documented by an inability to tolerate at least two chemically distinct statins**

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

Document statin intolerance:_____

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

Document statin intolerance:_____

☐ **Patient has an FDA labeled contraindication to all statins:**

Document contraindication: _____

Renewals:

Is patient continuing lipid lowering therapy at a maximally tolerated dose? ☐ Yes ☐ No

Is patient intolerant to or has a contraindication to statins? ☐ Yes ☐ No

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

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Document positive response to therapy: _____

_____

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.*