

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



**Keystone First**

**PERFORMRx**<sup>SM</sup>  
Next Generation Pharmacy Benefits

Fax to PerformRx<sup>SM</sup> at **1-866-497-1387**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION			
<input type="checkbox"/> New request <input type="checkbox"/> 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			
<b>Medication requested:</b>			
Preferred:		Non-Preferred:	
<input type="checkbox"/> Cholestyramine Powder <input type="checkbox"/> Cholestyramine Powder Packet <input type="checkbox"/> Cholestyramine Light Powder <input type="checkbox"/> Cholestyramine Light Powder Packet <input type="checkbox"/> Colestipol Tablet <input type="checkbox"/> Ezetimibe Tablet <input type="checkbox"/> Fenofibrate 54 mg Tablet (generic Lofibra Tablet) <input type="checkbox"/> Fenofibrate 160 mg Tablet (generic Lofibra Tablet) <input type="checkbox"/> Fenofibrate Micronized 43 mg Capsule (generic Antara) <input type="checkbox"/> Fenofibrate Micronized 130 mg Capsule (generic Antara) <input type="checkbox"/> Fenofibrate Micronized 67 mg Capsule (generic Lofibra Capsule) <input type="checkbox"/> Fenofibrate Micronized 134 mg Capsule (generic Lofibra Capsule) <input type="checkbox"/> Fenofibrate Micronized 200 mg Capsule (generic Lofibra Capsule) <input type="checkbox"/> Fenofibrate Nanocrystalized 48 mg Tablet (generic Tricor)	<input type="checkbox"/> Fenofibrate Nanocrystalized 145 mg Tablet (generic Tricor) <input type="checkbox"/> Fenofibric Acid (Choline) DR 45 mg Capsule (generic Trilipix) <input type="checkbox"/> Fenofibric Acid (Choline) DR 135 mg Capsule (generic Trilipix) <input type="checkbox"/> Gemfibrozil Tablet <input type="checkbox"/> Nexletol Tablet <input type="checkbox"/> Nexlizet Tablet <input type="checkbox"/> Omega-3 Ethyl Esters Capsule (generic Lovaza) <input type="checkbox"/> Praluent Pen <input type="checkbox"/> Prevalite Powder <input type="checkbox"/> Prevalite Powder Packet <input type="checkbox"/> Repatha Pushtronex <input type="checkbox"/> Repatha Sureclick <input type="checkbox"/> Repatha Syringe	<input type="checkbox"/> Colesevelam Powder Packet <input type="checkbox"/> Colesevelam Tablet <input type="checkbox"/> Colestid Granule <input type="checkbox"/> Colestid Tablet <input type="checkbox"/> Colestipol Granule <input type="checkbox"/> Colestipol Granule Packet <input type="checkbox"/> Evkeeza Vial <input type="checkbox"/> Fenofibrate 50 mg Capsule (generic Lipofen) <input type="checkbox"/> Fenofibrate 150 mg Capsule (generic Lipofen) <input type="checkbox"/> Fenofibrate 40 mg Tablet (generic Fenoglide) <input type="checkbox"/> Fenofibrate 120 mg Tablet (generic Fenoglide) <input type="checkbox"/> Fenofibrate (Micronized) 90 mg Capsule (generic Antara) <input type="checkbox"/> Fenofibric Acid 35 mg Tablet (generic Fibracor)	<input type="checkbox"/> Fenofibric Acid 105 mg Tablet (generic Fibracor) <input type="checkbox"/> Icosapent Ethyl Capsule (generic Vascepa) <input type="checkbox"/> Juxtapid Capsule <input type="checkbox"/> Leqvio Syringe <input type="checkbox"/> Lipofen Capsule <input type="checkbox"/> Lopid Tablet <input type="checkbox"/> Lovaza Capsule <input type="checkbox"/> Niacin ER Tablet (generic Niaspan) <input type="checkbox"/> Questran Powder <input type="checkbox"/> Questran Powder Packet <input type="checkbox"/> Questran Light Powder <input type="checkbox"/> Tricor Tablet <input type="checkbox"/> Tryngolza Autoinjector <input type="checkbox"/> Welchol Powder Packet <input type="checkbox"/> Welchol Tablet <input type="checkbox"/> Zetia Tablet
Dosage form:			Strength:
Dose/directions:		Quantity:	Refills:
Diagnosis:			Dx code <i>(required)</i> :

**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 JXTAPID (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 PCSK9 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: _____
-----------------------------	-------------

**Confidentiality Notice:** The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or taking of any telecopy is strictly prohibited.