**Cardiovascular Agents: Lipotropics**

|  |  |
| --- | --- |
| Criteria 1 | NP- HMG-CoA Reductase Inhibitors - Altoprev, Atorvaliq, Ezallor, Fluvastatin, Livalo, Zypitamag Amlodipine/Atorvastatin, Ezetimibe/Simvastatin |
| Criteria 2 | NP- Niacin Derivatives - Niacin ER Tab |
| Criteria 3 | NP- Fibrates - Fenofibrate Cap, Fenofibrate 40, 54, 120, 160mg Tab, Fenofibric Acid |
| Criteria 4 | NP- ATP Citrate Lyase (ACL) Inhibitors - Nexletol, Nexlizet |
| Criteria 5 | NP- Bile Acid Sequestrants – Colesevelam, Colestipol Granules |
| Criteria 6 | NP- Juxtapid |
| Criteria 7 | NP- Omega- 3 Fatty Acids- Vascepa, Icosapent Ethyl |
| Criteria 8 | P- PCSK-9 Inhibitors- Praluent (P, PA), Repatha (P, PA) |

|  |  |  |  |
| --- | --- | --- | --- |
| **Criteria Title** | Cardiovascular Agents: Lipotropics | | |
| **Criteria Subtitle** | Non-Preferred- HMG-CoA Reductase Inhibitors and Combination Products | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| ALTOPREV | 050556 | GCNSeqNo |
| ALTOPREV | 050557 | GCNSeqNo |
| ALTOPREV | 050558 | GCNSeqNo |
| ATORVALIQ | 084377 | GCNSeqNo |
| EZALLOR | 079379 | GCNSeqNo |
| EZALLOR | 079380 | GCNSeqNo |
| EZALLOR | 079381 | GCNSeqNo |
| EZALLOR | 079382 | GCNSeqNo |
| FLUVASTATIN | 021694 | GCNSeqNo |
| FLUVASTATIN | 021695 | GCNSeqNo |
| FLUVASTATIN | 046757 | GCNSeqNo |
| LIVALO | 066349 | GCNSeqNo |
| LIVALO | 066350 | GCNSeqNo |
| LIVALO | 066351 | GCNSeqNo |
| ZYPITAMAG | 077568 | GCNSeqNo |
| ZYPITAMAG | 077569 | GCNSeqNo |
| AMLODIPINE/ATORVASTATIN | 053689 | GCNSeqNo |
| AMLODIPINE/ATORVASTATIN | 053690 | GCNSeqNo |
| AMLODIPINE/ATORVASTATIN | 053691 | GCNSeqNo |
| AMLODIPINE/ATORVASTATIN | 053692 | GCNSeqNo |
| AMLODIPINE/ATORVASTATIN | 053693 | GCNSeqNo |
| AMLODIPINE/ATORVASTATIN | 053694 | GCNSeqNo |
| AMLODIPINE/ATORVASTATIN | 053695 | GCNSeqNo |
| AMLODIPINE/ATORVASTATIN | 053696 | GCNSeqNo |
| AMLODIPINE/ATORVASTATIN | 058432 | GCNSeqNo |
| AMLODIPINE/ATORVASTATIN | 058433 | GCNSeqNo |
| AMLODIPINE/ATORVASTATIN | 058434 | GCNSeqNo |
| EZETIMIBE/SIMVASTATIN | 057859 | GCNSeqNo |
| EZETIMIBE/SIMVASTATIN | 057863 | GCNSeqNo |
| EZETIMIBE/SIMVASTATIN | 057864 | GCNSeqNo |
| EZETIMIBE/SIMVASTATIN | 057865 | GCNSeqNo |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0997 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0998 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0998 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 0999 |
| N | 1235 |
| 3 | 0999 |  | Select | What product is being requested? | Altoprev | 1000 |
| Fluvastatin | 1000 |
| Livalo | 1000 |
| Other | 1001 |
| 4 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days with two preferred drugs in the same drug class?  The preferred product(s) are as follows: Atorvastatin, Lovastatin, Pravastatin, Rosuvastatin, Simvastatin  If yes, please submit the medication trials and dates. | Y | 1003 |
| N | 1002 |
| 5 | 1001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days with at least one preferred drug in the same drug class?  The preferred product(s) are as follows: Atorvastatin, Lovastatin, Pravastatin, Rosuvastatin, Simvastatin  If yes, please submit the medication trials and dates. | Y | 1003 |
| N | 1002 |
| 6 | 1002 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1003 |
| N | 1236 |
| 7 | 1003 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1004 |
| N | END (Approve x 365 days) |
| 8 | 1004 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Approve x 365 days) |
| N | 1235 |
| 9 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Approve x 365 days) |
| N | 1235 |
| 10 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 11 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 days

|  |  |
| --- | --- |
| **Last Approved** | 8/11/2023 |
| **Other** |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Criteria Title** | | | Cardiovascular Agents: Lipotropics | | | | | | |
| **Criteria Subtitle** | | | Non-Preferred- Niacin Derivatives | | | | | | |
| **Approval Level** | | | GCNSeqNo | | | | | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | | | Drug Name | | Corresponding Code (s) | | Type of Code (GCNSeqNo, HICL, NDC) | | |
| NIACIN ER TAB | | 033364 | | GCNSeqNo | | |
| NIACIN ER TAB | | 033365 | | GCNSeqNo | | |
| NIACIN ER TAB | | 033366 | | GCNSeqNo | | |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | | **Question Type** | | **Question Text** | | **Choice Text** | **Next Question ID** | |
| 1 | 0998 |  | | Select | | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | | New Start (initial authorization request) | 0999 | |
| Continuation (re-authorization request) | 1234 | |
| 2 | 0999 |  | | Select | | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | | Y | 1000 | |
| N | 1235 | |
| 3 | 1000 |  | | Select and Free Text | | Has the patient had an inadequate clinical response of at least 30 days with at least one preferred drug in the same drug class?  The preferred product(s) are as follows: Niacin IR, Niacin ER OTC  If yes, please submit the medication trials and dates. | | Y | 1002 | |
| N | 1001 | |
| 4 | 1001 |  | | Select and Free Text | | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | | Y | 1002 | |
| N | 1236 | |
| 5 | 1002 |  | | Select | | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | | Y | 1003 | |
| N | END (Approve x 365 days) | |
| 6 | 1003 |  | | Select and Free Text | | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | | Y | END (Approve x 365 days) | |
| N | 1235 | |
| 7 | 1234 |  | | Select and Free Text | | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | | Y | END (Approve x 365 days ) | |
| N | 1235 | |
| 8 | 1235 |  | | Free Text | | Please provide the rationale for the medication being requested. | | END (Pending Manual Review) | | |
| 9 | 1236 |  | | Free Text | | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | | END (Pending Manual Review) | | |

LENGTH OF AUTHORIZATIONS: 365 days

|  |  |
| --- | --- |
| **Last Approved** | 8/11/2023 |
| **Other** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Criteria Title** | Cardiovascular Agents: Lipotropics | | |
| **Criteria Subtitle** | Non-Preferred- Fibrate Deriviatives- Fenofibrate Cap, Fenofibrate 40, 54, 120, 160mg Tab, Fenofibric Acid | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| FENOFIBRATE CAP | 063024 | GCNSeqNo |
| FENOFIBRATE CAP | 063025 | GCNSeqNo |
| FENOFIBRATE CAP | 043060 | GCNSeqNo |
| FENOFIBRATE CAP | 043061 | GCNSeqNo |
| FENOFIBRATE CAP | 044305 | GCNSeqNo |
| FENOFIBRATE CAP | 058479 | GCNSeqNo |
| FENOFIBRATE CAP | 058480 | GCNSeqNo |
| FENOFIBRATE CAP | 071642 | GCNSeqNo |
| FENOFIBRATE CAP | 071643 | GCNSeqNo |
| FENOFIBRATE 40, 54, 120, 160 mg TAB | 044915 | GCNSeqNo |
| FENOFIBRATE 40, 54, 120, 160 mg TAB | 063693 | GCNSeqNo |
| FENOFIBRATE 40, 54, 120, 160 mg TAB | 063694 | GCNSeqNo |
| FENOFIBRATE 40, 54, 120, 160 mg TAB | 064310 | GCNSeqNo |
| FENOFIBRIC ACID | 064676 | GCNSeqNo |
| FENOFIBRIC ACID | 064677 | GCNSeqNo |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0998 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1000 |
| N | 1235 |
| 3 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 90 days with at least one preferred drug in the same drug class?  The preferred product(s) are as follows: Fenofibrate 48mg Tab, Fenofibrate 145mg Tab, Gemfibrozil  If yes, please submit the medication trials and dates. | Y | 1002 |
| N | 1001 |
| 4 | 1001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1002 |
| N | 1236 |
| 5 | 1002 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1003 |
| N | END (Approve x 365 days) |
| 6 | 1003 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Approve x 365 days) |
| N | 1235 |
| 7 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Approve x 365 days) |
| N | 1235 |
| 8 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 9 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 days

|  |  |
| --- | --- |
| **Last Approved** | 8/11/2023 |
| **Other** |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Criteria Title** | | Cardiovascular Agents: Lipotropics | | | | | | | |
| **Criteria Subtitle** | | Non-Preferred- ACL Inhibitors - Nexletol, Nexlizet | | | | | | | |
| **Approval Level** | | GCNSeqNo | | | | | | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | | Drug Name | | | Corresponding Code (s) | | Type of Code (GCNSeqNo, HICL, NDC) | | |
| NEXLETOL | | | 080782 | | GCNSeqNo | | |
| NEXLIZET | | | 080790 | | GCNSeqNo | | |
| **Sequence Number** | **Question ID** | | **Default Next Question ID** | **Question Type** | | **Question Text** | | **Choice Text** | **Next Question ID** | |
| 1 | 0998 | |  | Select | | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | | New Start (initial authorization request) | 0999 | |
| Continuation (re-authorization request) | 1234 | |
| 2 | 0999 | |  | Select | | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | | Y | 1000 | |
| N | 1235 | |
| 3 | 1000 | |  | Select and Free Text | | Has the provider submitted documentation of baseline labs **AND** documented adherence to 90 days of prescribed lipid lowering medications? | | Y | 1001 | |
| N | 1235 | |
| 4 | 1001 | |  | Select and Free Text | | Has the patient had an inadequate clinical response of at least 90 days **AND** is unable to reach goal LDL-C with high-potency statin, ezetimibe, and PCSK9 inhibitor?  Please note:   1. High potency statins: atorvastatin 40-80mg & rosuvastatin 20-40mg 2. LDL goals for Familial Hypercholesterolemia (FH) (includes Heterozygous & Homozygous FH): LDL less than or equal to 100mg/dL for adults or LDL less than or equal to 110mg/dL for those less than 18 years of age. 3. LDL goals for Clinical Atherosclerotic Cardiovascular Disease (ASCVD): LDL less than or equal to 70mg/dL   If yes, please submit the medication trials and dates. | | Y | 1003 | |
| N | 1002 | |
| 5 | 1002 | |  | Select and Free Text | | Is there a clinical reason that these drugs (high-potency statin, ezetimibe and PCSK9 inhibitor) cannot be utilized?  If yes, please submit documentation. | | Y | 1003 | |
| N | 1235 | |
| 6 | 1003 | |  | Select | | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | | Y | 1004 | |
| N | END (Pending Manual Review) | |
| 7 | 1004 | |  | Select and Free Text | | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 8 | 1234 | |  | Select and Free Text | | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 9 | 1235 | |  | Free Text | | Please provide the rationale for the medication being requested. | | END (Pending Manual Review) | | |

LENGTH OF AUTHORIZATIONS: Initial- 84 days; Subsequent- 365 days

|  |  |
| --- | --- |
| **Last Approved** | 8/11/2023 |
| **Other** |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Criteria Title** | | | Cardiovascular Agents: Lipotropics | | | | | | |
| **Criteria Subtitle** | | | Non-Preferred- Bile Acid Sequestrants - Colesevelam, Colestipol Granules | | | | | | |
| **Approval Level** | | | GCNSeqNo | | | | | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | | | Drug Name | | | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) | | |
| COLESEVELAM | | | 046172 | GCNSeqNo | | |
| COLESTIPOL GRANULES | | | 003101 | GCNSeqNo | | |
| COLESTIPOL GRANULES | | | 003102 | GCNSeqNo | | |
| COLESTIPOL GRANULES | | | 021429 | GCNSeqNo | | |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | | **Question Type** | **Question Text** | | | **Choice Text** | **Next Question ID** | |
| 1 | 0998 |  | | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | | | New Start (initial authorization request) | 0999 | |
| Continuation (re-authorization request) | 1234 | |
| 2 | 0999 |  | | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | | | Y | 1000 | |
| N | 1235 | |
| 3 | 1000 |  | | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days with at least one preferred drug in the same drug class?  The preferred product(s) are as follows: Cholestyramine Regular, Cholestyramine Light, Colestipol Tab, Prevalite  If yes, please submit the medication trials and dates. | | | Y | 1002 | |
| N | 1001 | |
| 4 | 1001 |  | | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | | | Y | 1002 | |
| N | 1236 | |
| 5 | 1002 |  | | Select | What product is being requested? | | | Colesevelam | 1003 | |
| Colestipol Granules | 1004 | |
| Other | 1235 | |
| 6 | 1003 |  | | Select and Free Text | Has the provider submitted documentation of a Type 2 Diabetes diagnosis? | | | Y | 1004 | |
| N | 1235 | |
| 7 | 1004 |  | | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | | | Y | 1005 | |
| N | END (Approve x 365 days) | |
| 8 | 1005 |  | | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | | | Y | END (Approve x 365 days) | |
| N | 1235 | |
| 9 | 1234 |  | | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | | | Y | END (Approve x 365 days) | |
| N | 1235 | |
| 10 | 1235 |  | | Free Text | Please provide the rationale for the medication being requested. | | | END (Pending Manual Review) | | |
| 11 | 1236 |  | | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | | | END (Pending Manual Review) | | |

LENGTH OF AUTHORIZATIONS: 365 days

|  |  |
| --- | --- |
| **Last Approved** | 8/11/2023 |
| **Other** |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Criteria Title** | | | Cardiovascular Agents: Lipotropics | | | | | | |
| **Criteria Subtitle** | | | Juxtapid | | | | | | |
| **Approval Level** | | | GCNSeqNo | | | | | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | | | Drug Name | | Corresponding Code (s) | | Type of Code (GCNSeqNo, HICL, NDC) | | |
| JUXTAPID | | 070393 | | GCNSeqNo | | |
| JUXTAPID | | 070394 | | GCNSeqNo | | |
| JUXTAPID | | 070395 | | GCNSeqNo | | |
| JUXTAPID | | 074053 | | GCNSeqNo | | |
| JUXTAPID | | 074054 | | GCNSeqNo | | |
| JUXTAPID | | 074055 | | GCNSeqNo | | |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | | **Question Type** | | **Question Text** | | **Choice Text** | **Next Question ID** | |
| 1 | 0998 |  | | Select | | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | | New Start (initial authorization request) | 0999 | |
| Continuation (re-authorization request) | 1234 | |
| 2 | 0999 |  | | Select | | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | | Y | 1000 | |
| N | 1235 | |
| 3 | 1000 |  | | Select and Free Text | | Has the provider submitted documentation of baseline labs **AND** documented adherence to 90 days of prescribed lipid lowering medications? | | Y | 1001 | |
| N | 1235 | |
| 4 | 1001 |  | | Select and Free Text | | Has the patient had an inadequate clinical response of at least 90 days **AND** is unable to reach goal LDL-C with high-potency statin, ezetimibe, and PCSK9 inhibitor?  Please note:   1. High potency statins: atorvastatin 40-80mg & rosuvastatin 20-40mg 2. LDL goals for Familial Hypercholesterolemia (FH) (includes Heterozygous & Homozygous FH): LDL less than or equal to 100mg/dL for adults or LDL less than or equal to 110mg/dL for those less than 18 years of age. 3. LDL goals for Clinical Atherosclerotic Cardiovascular Disease (ASCVD): LDL less than or equal to 70mg/dL   If yes, please submit the medication trials and dates. | | Y | 1003 | |
| N | 1002 | |
| 5 | 1002 |  | | Select and Free Text | | Is there a clinical reason that these drugs (high-potency statin, ezetimibe and PCSK9 inhibitor) cannot be utilized?  If yes, please submit documentation. | | Y | 1003 | |
| N | 1235 | |
| 6 | 1003 |  | | Select | | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | | Y | 1004 | |
| N | END (Pending Manual Review) | |
| 7 | 1004 |  | | Select and Free Text | | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 8 | 1234 |  | | Select and Free Text | | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 9 | 1235 |  | | Free Text | | Please provide the rationale for the medication being requested. | | END (Pending Manual Review) | | |
| 10 | 1236 |  | | Free Text | | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | | END (Pending Manual Review) | | |

LENGTH OF AUTHORIZATIONS: Initial- 180 days; Subsequent- 365 days

|  |  |
| --- | --- |
| **Last Approved** | 8/11/2023 |
| **Other** |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Criteria Title** | | | Cardiovascular Agents: Lipotropics | | | | | | |
| **Criteria Subtitle** | | | Non-Preferred- Omega-3 Fatty Acids Vascepa, Icosapent Ethyl | | | | | | |
| **Approval Level** | | | GCNSeqNo | | | | | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | | | Drug Name | | Corresponding Code (s) | | Type of Code (GCNSeqNo, HICL, NDC) | | |
| ICOSAPENT ETHYL | | 069960 | | GCNSeqNo | | |
| ICOSAPENT ETHYL | | 076660 | | GCNSeqNo | | |
| VASCEPA | | 069960 | | GCNSeqNo | | |
| VASCEPA | | 076660 | | GCNSeqNo | | |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | | **Question Type** | | **Question Text** | | **Choice Text** | **Next Question ID** | |
| 1 | 0998 |  | | Select | | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | | New Start (initial authorization request) | 0999 | |
| Continuation (re-authorization request) | 1234 | |
| 2 | 0999 |  | | Select | | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | | Y | 1000 | |
| N | 1235 | |
| 3 | 1000 |  | | Select and Free Text | | Has the patient had an inadequate clinical response of at least 30 days with at least one preferred drug in the same drug class?  The preferred product(s) are as follows: Omega-3-Acid Ethyl Esters  If yes, please submit the medication trials and dates. | | Y | 1002 | |
| N | 1001 | |
| 4 | 1001 |  | | Select and Free Text | | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | | Y | 1002 | |
| N | 1236 | |
| 5 | 1002 |  | | Select | | What product is being requested? | | Brand Vascepa | 1004 | |
| Generic icosapent ethyl | 1003 | |
| Other | 1235 | |
| 6 | 1003 |  | | Select and Free Text | | Has the brand medication been attempted and failed or is the brand medication contraindicated?  If yes, please submit documentation. | | Y | 1004 | |
| N | 1235 | |
| 7 | 1004 |  | | Select and Free Text | | Has the provider submitted documentation of baseline labs indicating triglyceride levels greater than or equal to 500mg/dL after an inadequate clinical response to fibrates, niacin, and diet/exercise? | | Y | 1005 | |
| N | 1235 | |
| 8 | 1005 |  | | Select and Free Text | | Has the provider submitted documentation of discontinuation of drugs known to increase triglyceride levels (i.e., beta blockers, thiazides, and estrogens), if clinically appropriate? | | Y | 1006 | |
| N | 1235 | |
| 9 | 1006 |  | | Select | | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | | Y | 1007 | |
| N | END (Pending Manual Review) | |
| 10 | 1007 |  | | Select and Free Text | | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 11 | 1234 |  | | Select and Free Text | | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 12 | 1235 |  | | Free Text | | Please provide the rationale for the medication being requested. | | END (Pending Manual Review) | | |
| 13 | 1236 |  | | Free Text | | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | | END (Pending Manual Review) | | |

LENGTH OF AUTHORIZATIONS: Initial- 84 days; Subsequent- 365 days

|  |  |
| --- | --- |
| **Last Approved** | 8/11/2023 |
| **Other** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Criteria Title** | Cardiovascular Agents: Lipotropics | | |
| **Criteria Subtitle** | Preferred- PCSK-9 Inhibitors - Praluent (P, PA), Repatha (P, PA) | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| PRALUENT | 074511 | GCNSeqNo |
| PRALUENT | 074513 | GCNSeqNo |
| REPATHA | 074564 | GCNSeqNo |
| REPATHA | 074663 | GCNSeqNo |
| REPATHA | 076353 | GCNSeqNo |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0998 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1000 |
| N | 1235 |
| 3 | 1000 |  | Select and Free Text | Has the provider submitted documentation of baseline labs **AND** documented adherence to 90 days of prescribed lipid lowering medications? | Y | 1001 |
| N | 1235 |
| 4 | 1001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 90 days **AND** is unable to reach goal LDL-C despite treatment with maximally tolerated dose of high-potency statin and ezetimibe?  Please note:   1. High potency statins: atorvastatin 40-80mg & rosuvastatin 20-40mg 2. LDL goals for Familial Hypercholesterolemia (FH) (includes Heterozygous & Homozygous FH): LDL less than or equal to 100mg/dL for adults or LDL less than or equal to 110mg/dL for those less than 18 years of age. 3. LDL goals for Clinical Atherosclerotic Cardiovascular Disease (ASCVD): LDL less than or equal to 70mg/dL   If yes, please submit the medication trials and dates. | Y | END (Pending Manual Review) |
| N | 1002 |
| 5 | 1002 |  | Select and Free Text | Is there a clinical reason that these drugs (high-potency statin, ezetimibe) cannot be utilized?  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 1235 |
| 6 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 7 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 days

|  |  |
| --- | --- |
| **Last Approved** | 8/11/2023 |
| **Other** |  |