Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Print Clear

Lipid Lowering Agent
Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at **www.mass.gov/druglist.**

Member information

Last name _____ First name _____ MI _____

MassHealth member ID # _____ Date of birth _____

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Statins: Refer to Sections I, II, and/or VII as applicable.

☐ Altoprev (lovastatin extended-release)
☐ atorvastatin > quantity limits
☐ atorvastatin/amlodipine
☐ fluvastatin
☐ fluvastatin extended-release
☐ Liptruzet (ezetimibe/atorvastatin)
☐ Livalo (pitavastatin)
☐ lovastatin > quantity limits
☐ pravastatin > quantity limits
☐ rosuvastatin > quantity limits
☐ simvastatin > quantity limits
☐ simvastatin/ezetimibe

Other Lipid Lowering Agents: Refer to Sections I through VII as applicable.

Other* _____

_____

*If request is for a non-preferred brand name or generic product, please attach supporting documentation (e.g., copies of medical records and/ or office notes regarding adverse reaction or inadequate response to the preferred product).

Fibric Acids: Refer to Section III.

☐ Antara (fenofibrate capsule 30 mg, 90 mg)
☐ fenofibrate capsule 130 mg
☐ fenofibrate capsule 150 mg
☐ fenofibrate tablet 145 mg
☐ fenofibrate tablet 40 mg, 120 mg
☐ Triglide (fenofibrate tablet 160 mg)

Cholesterol Absorption Inhibitors: Refer to Sections I and II as applicable.

☐ ezetimibe

Miscellaneous Agents: Refer to Sections IV and V as applicable.

☐ colesevelam
☐ omega 3-acid ethyl esters
☐ Vascepa (icosapent ethyl)

PCSK9 Inhibitors: Refer to Section VI.

☐ Praluent (alirocumab)
☐ Repatha (evolocumab)

Dose, frequency, and duration of requested drug, and quantity/month _____

_____

Diagnosis and Provider Specialty: Please complete for all requests

Indication for medication requested (Check all that apply.)

☐ Heterozygous familial hypercholesterolemia
☐ Homozygous familial hypercholesterolemia
☐ Hypertriglyceridemia
☐ Primary hypercholesterolemia
☐ Mixed dyslipidemia
☐ Secondary prevention of cardiovascular event
☐ Other. Specify pertinent medical history, diagnostic studies, and/or laboratory results.

_____

_____

Please indicate prescriber specialty:

☐ Cardiology
☐ Other
☐ Specialist consult details (if the prescriber submitting the request is not a specialist)

Name(s) of the specialist(s) _____

_____

Date(s) of last visit or consult _____

_____

Contact Information _____

_____

Lab Values and Treatment Plan: Please complete for all requests

1. Is this a request for treatment initiation?

☐ Yes. Please provide the current baseline laboratory values.

☐ No.

Date _____

Total cholesterol _____ mg/dl
HDL _____ mg/dl
LDL/LDL-C _____ mg/dl
Triglycerides _____ mg/dl

2. Is this a request for continuation of treatment?

☐ Yes. Please provide the current laboratory values following treatment demonstrating efficacy of the requested agent.

☐ No.

Date _____

Total cholesterol _____ mg/dl
HDL _____ mg/dl
LDL/LDL-C _____ mg/dl
Triglycerides _____ mg/dl

3. Please summarize treatment goals including target cholesterol levels.

_____

_____

_____

_____

Section I. Please complete if this request is for Altoprev, atorvastatin/amlodipine, ezetimibe, fluvastatin, fluvastatin extended-release, Liptruzet, Livalo, or simvastatin/ezetimibe.

1. Has the member had an inadequate response to rosuvastatin at a dose of at least 40 mg/day for at least three months? ☐ Yes. ☐ No.
2. Has the member tried rosuvastatin and had an adverse reaction? ☐ Yes.
   Please explain. _____ ☐ No.
3. Does the member have a contraindication to rosuvastatin? ☐ Yes.
   Please explain. _____ ☐ No.

Section II. Please complete for requests for quantities above quantity limits.

Please attach documentation of the clinical rationale for the requested dose, quantity, and frequency, including a detailed treatment plan. Specify pertinent medical history, diagnostic studies, and/or lab results.

Section III. Please complete if this request is for brand-name fenofibrate (Antara, Fenoglide, Lipofen, Lofibra, or Triglide), fenofibrate capsule 130 mg, fenofibrate capsule 150 mg, fenofibrate tablet 40 mg, 120 mg, and fenofibrate tablet 145 mg.

Please attach medical records documenting failure with a therapeutically equivalent fenofibrate formulation.

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Section IV. Please complete if this request is for omega 3-acid ethyl esters or Vascepa.

1. Has the member had an adverse reaction or inadequate response to a fibric acid derivative? ☐ Yes. ☐ No.
   Drug _____ Dates of use _____ Outcome _____
2. Does the member have a contraindication to fibric acids?
   ☐ Yes. Please explain. _____ ☐ No.
3. Has the member had an adverse reaction or inadequate response to niacin? ☐ Yes. ☐ No.
   Drug _____ Dates of use _____ Outcome _____
4. Does the member have a contraindication to niacin?
   ☐ Yes. Please explain. _____ ☐ No.

Section V. Please complete if request is for colesevelam.

1. Has the member had an inadequate response to rosuvastatin at a dose of at least 40 mg/day for at least three months? ☐ Yes. ☐ No.
2. Has the member tried rosuvastatin and had an adverse reaction?
   ☐ Yes. Please explain. _____ ☐ No.
3. Has the member had an adverse reaction or inadequate response to cholestyramine or colestipol?
   ☐ Yes. ☐No.
   Drug _____ Dates of use _____ Outcome _____
4. Does the member have a contraindication to cholestyramine or colestipol? ☐ Yes. ☐ No.
   If yes, please explain. _____

Section VI. Please complete if this request is for Praluent or Repatha.

1. Has the member had an inadequate response to rosuvastatin at a dose of at least 40 mg/day in combination with ezetimibe at a dose of at least 10 mg/ day for at least the past three months?
   ☐ Yes. Please note: Requests will be evaluated taking into account MassHealth pharmacy claims history or additional documentation addressing adherence to this agent.
   ☐ rosuvastatin: Dose and frequency _____ Dates of use _____
   Outcome _____
   ☐ ezetimibe: Dose and frequency _____ Dates of use _____
   Outcome _____
   ☐ No.
2. Has the member tried rosuvastatin and had an adverse reaction or does the member have a contraindication to this agent?
   ☐ Yes. Please explain. _____ ☐ No.
3. Has the member tried ezetimibe and had an adverse reaction or does the member have a contraindication to this agent?
   ☐ Yes. Please explain. _____ ☐ No.
4. Will the requested agent be used in combination with a statin?
   ☐ Yes. Please note: Requests will be evaluated taking into account MassHealth pharmacy claims history or additional documentation addressing adherence to this agent.
   ☐ No. Please explain. _____
5. If this is a request for continuation of treatment, has the member been adherent to the lipid lowering regimen?
   ☐ Yes. Please note: Continued approval of the requested agent will be contingent upon MassHealth pharmacy claims history or additional documentation addressing adherence to the entire lipid lowering regimen.
   ☐ No

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Section VII. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

_____

_____

_____

Prescriber information

Last name* _____ First name* _____ MI _____

NPI* _____ Individual MH Provider ID _____

DEA No. _____ Office Contact Name _____

Address _____ City _____ State _____ Zip _____

E-mail address _____

Telephone No.* _____ Fax No.* _____

* *Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____