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

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# Lipid-Lowering Agents
# 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**

- ☐ Altoprev (lovastatin extended-release)
- ☐ atorvastatin > quantity limits
- ☐ atorvastatin/amlodipine
- ☐ Ezallor (rosuvastatin sprinkle capsule)
- ☐ fluvastatin
- ☐ fluvastatin extended-release
- ☐ Livalo (pitavastatin calcium)
- ☐ lovastatin > quantity limits
- ☐ pravastatin > quantity limits
- ☐ rosuvastatin > quantity limits
- ☐ simvastatin > quantity limits
- ☐ simvastatin/ezetimibe > quantity limits
- ☐ Zypitamag (pitavastatin magnesium)

**Fibric Acids**

- ☐ fenofibrate tablet 40 mg, 120 mg

**Miscellaneous Agents**

- ☐ icosapent ethyl
- ☐ Nexletol (bempedoic acid)
- ☐ Nexlizet (bempedoic acid/ezetimibe)

**PCSK9 Inhibitors**

- ☐ Praluent (alirocumab)
- ☐ Repatha (evolocumab)

**Other Lipid-Lowering Agents**

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).*

**Dose, frequency, and duration of requested medication** _____ **Quantity requested per month** _____

**Indication** (Check all that apply.)

- ☐ Atherosclerotic cardiovascular (CV) disease
- ☐ CV risk reduction
- ☐ Heterozygous familial hypercholesterolemia
- ☐ Homozygous familial hypercholesterolemia
- ☐ Hypercholesterolemia
- ☐ Hypercholesterolemia with previous history of any cardiovascular event
- ☐ Hypertriglyceridemia
- ☐ Mixed dyslipidemia
- ☐ 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 _____

Is this member a referral candidate for care coordination? ☐ Yes ☐ No

If yes, MassHealth will offer care coordination services to this member. Please describe which additional behavioral health services would be beneficial.

_____

**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.

   Date _____

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

   HDL _____ mg/dl Triglycerides _____ mg/dl

   ☐ No

2. Is this a request for continuation of treatment?

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

   Date _____

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

   HDL _____ mg/dl Triglycerides _____ mg/dl

   ☐ No

3. Please summarize treatment goals including target cholesterol levels.

   _____

   _____

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

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 if this request is 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 fenofibrate tablet 40 mg or 120 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 icosapent ethyl for hypertriglyceridemia (not inclusive of those with established cardiovascular disease (CVD) or diabetes mellitus and CV risk factors).

1. Has the member had a trial with omega-3 acid ethyl esters?
   ☐ Yes. Please list the dose and frequency, dates/duration of trial, and outcome below.
   Dose and frequency _____ Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Please document if there is a contraindication to omega-3 acid ethyl esters.
   _____
2. Has the member had a trial with a fibric acid derivative?
   ☐ Yes. Please list the drug name, dose and frequency, dates/duration of trials, and outcomes below.
   Drug name _____ Dose and frequency _____ Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Please document if there is a contraindication to all fibric acid derivatives.
   _____

## Section V. Please complete if this request is for icosapent ethyl for cardiovascular risk reduction.

1. Does the member have established cardiovascular disease (CVD)?
   ☐ Yes. Please describe. _____
   ☐ No
2. Does the member have diabetes mellitus with at least two risk factors for CVD?
   ☐ Yes. Please describe. _____
   ☐ No
3. Will icosapent ethyl will be used in combination with a statin?
   ☐ Yes
   ☐ No. Clinical rationale why member cannot take a statin. _____

## 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

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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

## Section VII. Please complete if this request is for Ezallor.

Has the member had a trial with rosuvastatin tablet?

☐ Yes. Please list the dates/duration of trial and outcomes below.
Dates/duration of use _____
Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
Briefly describe details of adverse reaction, inadequate response, or other.

_____

☐ No. Please document if there is a medical necessity for the use of a sprinkle capsule formulation.

_____

## Section VIII. Please complete if this request is for Nexletol or Nexlizet.

1. Has the member had an inadequate response to atorvastatin at a dose of at least 80 mg/day or rosuvastatin at a dose of at least 40 mg/day in combination with ezetimibe 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.
   ☐ atorvastatin or rosuvastatin
   Drug name _____ Dose and frequency _____
   Dates of use _____ Outcome _____
   ☐ ezetimibe
   Dose and frequency _____ Dates of use _____ Outcome _____
   ☐ No
2. Has the member tried atorvastatin and had an adverse reaction or does the member have a contraindication to this agent?
   ☐ Yes. Please explain. _____ ☐ No
3. Has the member tried rosuvastatin and had an adverse reaction or does the member have a contraindication to this agent?
   ☐ Yes. Please explain. _____ ☐ No
4. For Nexletol, has the member tried ezetimibe and had an adverse reaction or does the member have a contraindication to this agent?
   ☐ Yes. Please explain. _____ ☐ No

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5. 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. _____

## Section IX. 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 _____