Gateway Health
It's Wholecare.

Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

I. Requirements for Prior Authorization of Lipotropics, Other

A. Prescriptions That Require Prior Authorization

Prescriptions for Lipotropics, Other that meet any of the following conditions must be prior authorized:

1. A non-preferred Lipotropic, Other. See the Preferred Drug List (PDL) for the list of preferred Lipotropics, Other at: https://papdl.com/preferred-drug-list.
2. A proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (e.g., Praluent [alirocumab], Repatha [evolocumab]).
3. An adenosine triphosphate-citrate lyase (ACL) inhibitor (e.g., Nexletol [bempedoic acid], Nexlizet [bempedoic acid/ezetimibe]).
4. A microsomal triglyceride transfer protein (MTP) inhibitor (e.g., Juxtapid [lomitapide]).
5. An angiopoietin-like 3 (ANGPTL3) inhibitor (e.g., Evkeeza [evinacumab]).

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Lipotropic, Other, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is prescribed the requested Lipotropic, Other for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication; **AND**
2. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
3. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
4. Does not have a contraindication to the prescribed medication; **AND**
5. For treatment of a lipid disorder, has documentation of results of a lipid profile within 3 months prior to the request for the Lipotropic, Other; **AND**
6. For a PCSK9 inhibitor, **all** of the following:
    a. Has at least **one** of the following:
        i. A history of clinical atherosclerotic cardiovascular disease (ASCVD)[1] (i.e., secondary prevention)
        ii. **One** of the following (i.e., primary prevention):
            a) A diagnosis of familial hypercholesterolemia in accordance with current consensus guidelines[2]
            b) A diagnosis of other severe primary hypercholesterolemia (baseline [before treatment with any lipid-lowering agent] LDL-C ≥190 mg/dL),

[1] Clinical ASCVD consists of acute coronary syndromes, history of myocardial infarction, stable or unstable angina or coronary or other arterial revascularization, stroke, transient ischemic attack, or peripheral artery disease including aortic aneurysm, all of atherosclerotic origin. (American Heart Association 2018 Cholesterol Clinical Practice Guidelines)
[2] e.g., American Heart Association, International Familial Hypercholesterolaemia Foundation, European Atherosclerosis Society, International Atherosclerosis Society

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b. Has a history of **one** of the following:

   i. Therapeutic failure[3] while adherent to treatment with the maximally tolerated doses of 2 different high-intensity statins for ≥3 consecutive months each,

   ii. **Both** of the following:

      a) A temporally related intolerance[4] to 2 high-intensity statins that occurred after **both** of the following:
         (i) Modifiable comorbid conditions that may enhance statin intolerance were ruled out and/or addressed by the prescriber as clinically indicated (e.g., hypothyroidism, vitamin D deficiency)
         (ii) All possible drug interactions with statins were addressed by **all** of the following (if clinically appropriate):
            a. Dose decrease of the interacting non-statin drug,
            b. Discontinuation of the interacting non-statin drug,
            c. Change to an alternative statin that has a lower incidence of drug interactions

      b) **One** of the following:
         (i) Therapeutic failure while adherent to treatment for ≥3 consecutive months with the lowest FDA-approved daily dose or alternate-day dosing of any statin
         (ii) A temporally related intolerance to the lowest FDA-approved daily dose or alternate-day dosing of any statin,

   iii. A contraindication to statins,

c. Has a history of **one** of the following:

   i. Therapeutic failure while adherent to treatment with ezetimibe in combination with the maximally tolerated dose of the highest-tolerated intensity statin (if clinically appropriate) for ≥3 consecutive months
   ii. A contraindication or an intolerance to ezetimibe,

d. Is prescribed the requested PCSK9 inhibitor in addition to **one** of the following:

   i. For treatment of homozygous familial hypercholesterolemia (HoFH), standard lipid-lowering treatments as recommended by current consensus guidelines[5]
   ii. For treatment of all other conditions, the maximally tolerated dose of the highest-tolerated intensity statin (if clinically appropriate),

e. If currently using a different PCSK9 inhibitor, will discontinue use of that PCSK9 inhibitor prior to starting the requested PCSK9 inhibitor,

[3] Therapeutic failure of a Lipotropic, Other is defined as failure to achieve LDL-C goal or percentage reduction of LDL-C for cardiovascular risk that is consistent with current consensus guidelines (e.g., AHA/ACC, AACE/ACE, etc).
[4] Temporally related intolerance of a statin is defined as the occurrence of symptoms and/or lab abnormalities upon initiation of a statin, resolution of symptoms and/or lab abnormalities upon discontinuation of a statin, and recurrence of symptoms and/or lab abnormalities after rechallenge with the same statin at the same dose.
[5] e.g., American Heart Association/American College of Cardiology, American Association of Clinical Endocrinologists/American College of Endocrinology, American Diabetes Association, National Lipid Association, European Society of Cardiology/European Atherosclerosis Society, International Familial Hypercholesterolaemia Foundation, International Atherosclerosis Society

f. For a non-preferred PCSK9 inhibitor, has a documented history of therapeutic failure of or a contraindication or an intolerance to the preferred PCSK9 inhibitor(s) approved or medically accepted for the beneficiary's diagnosis;

AND

7. For an ACL inhibitor, **all** of the following:

   a. Is prescribed the ACL inhibitor by or in consultation with an appropriate specialist (e.g., cardiologist, endocrinologist, or other provider specializing in lipid disorders),

   b. Has at least **one** of the following:
      i. A history of clinical ASCVD[6]
      ii. A diagnosis of familial hypercholesterolemia in accordance with current consensus guidelines,[7]

   c. Has a history of **one** of the following:

      i. Therapeutic failure[8] while adherent to treatment with the maximally tolerated doses of 2 different high-intensity statins for ≥3 consecutive months each,

      ii. **Both** of the following:
         a) A temporally related intolerance[9] to 2 high-intensity statins that occurred after **both** of the following:
            (i) Modifiable comorbid conditions that may enhance statin intolerance were ruled out and/or addressed by the prescriber as clinically indicated (e.g., hypothyroidism, vitamin D deficiency)
            (ii) All possible drug interactions with statins were addressed by **all** of the following (if clinically appropriate):
               a. Dose decrease of the interacting non-statin drug,
               b. Discontinuation of the interacting non-statin drug,
               c. Change to an alternative statin that has a lower incidence of drug interactions
         b) **One** of the following:
            (i) Therapeutic failure while adherent to treatment for ≥3 consecutive months with the lowest FDA-approved daily dose or alternate-day dosing of any statin
            (ii) A temporally related intolerance to the lowest FDA-approved daily dose or alternate-day dosing of any statin,

      iii. A contraindication to statins,

   d. Has a history of **both** of the following:

      i. **One** of the following:

[6] Clinical ASCVD consists of acute coronary syndromes, history of myocardial infarction, stable or unstable angina or coronary or other arterial revascularization, stroke, transient ischemic attack, or peripheral artery disease including aortic aneurysm, all of atherosclerotic origin. (American Heart Association 2018 Cholesterol Clinical Practice Guidelines)
[7] e.g., American Heart Association, International Familial Hypercholesterolaemia Foundation, European Atherosclerosis Society, International Atherosclerosis Society
[8] Therapeutic failure of a Lipotropic, Other is defined as failure to achieve LDL-C goal or percentage reduction of LDL-C for cardiovascular risk that is consistent with current consensus guidelines (e.g., AHA/ACC, AACE/ACE, etc).
[9] Temporally related intolerance of a statin is defined as the occurrence of symptoms and/or lab abnormalities upon initiation of a statin, resolution of symptoms and/or lab abnormalities upon discontinuation of a statin, and recurrence of symptoms and/or lab abnormalities after rechallenge with the same statin at the same dose.

a) Therapeutic failure while adherent to treatment with ezetimibe in combination with the maximally tolerated dose of the highest-tolerated intensity statin (if clinically appropriate) for ≥3 consecutive months
b) A contraindication or an intolerance to ezetimibe

ii. **One** of the following:
a) Therapeutic failure while adherent to treatment with a PCSK9 inhibitor
b) A contraindication or intolerance to PCSK9 inhibitors,

e. Is prescribed the requested ACL inhibitor in addition to the maximally tolerated dose of the highest-tolerated intensity statin (if clinically appropriate),

f. If currently taking simvastatin or pravastatin, will not be using the requested ACL inhibitor concomitantly with simvastatin at a dose of greater than 20 mg daily or pravastatin at a dose of greater than 40 mg daily;

AND

8. For an MTP inhibitor, **all** of the following:

a. Is prescribed the MTP inhibitor by or in consultation with a cardiologist, endocrinologist, or other provider specializing in lipid disorders,

b. For treatment of HoFH, has a diagnosis of HoFH in accordance with current consensus guidelines,[10]

c. **One** of the following:
i. Has a history of therapeutic failure of or a contraindication or an intolerance to PCSK9 inhibitors
ii. Is homozygous for LDL receptor (LDLR)-negative mutations (i.e., has LDLR-negative mutations in both alleles) associated with LDLR activity below 2%,

d. Is prescribed the MTP inhibitor in addition to standard lipid-lowering treatments as recommended by current consensus guidelines;[11]

AND

9. For an ANGPTL3 inhibitor, **all** of the following:

a. Is prescribed the ANGPTL3 inhibitor by or in consultation with a cardiologist, endocrinologist, or other provider specializing in lipid disorders,

b. For treatment of HoFH, has a diagnosis of HoFH in accordance with current consensus guidelines,[12]

c. **One** of the following:
i. Has a history of therapeutic failure of or a contraindication or an intolerance to PCSK9 inhibitors
ii. Is homozygous for LDLR-negative mutations (i.e., has LDLR-negative mutations in both alleles) associated with LDLR activity below 2%,

[10] e.g., American Heart Association, International Familial Hypercholesterolaemia Foundation, European Atherosclerosis Society, International Atherosclerosis Society
[11] e.g., American Heart Association/American College of Cardiology, American Association of Clinical Endocrinologists/American College of Endocrinology, American Diabetes Association, National Lipid Association, European Society of Cardiology/European Atherosclerosis Society, International Familial Hypercholesterolaemia Foundation, International Atherosclerosis Society
[12] e.g., American Heart Association, International Familial Hypercholesterolaemia Foundation, European Atherosclerosis Society, International Atherosclerosis Society

d. Is prescribed the ANGPTL3 inhibitor in addition to standard lipid-lowering treatments as recommended by current consensus guidelines;[13]

AND

10. For all other non-preferred Lipotropics, Other, has a history of therapeutic failure of or a contraindication or intolerance to the preferred Lipotropics, Other approved or medically accepted for the beneficiary's diagnosis.

    NOTE: If the beneficiary does not meet the clinical review guidelines but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR LIPOTROPICS, OTHER: The determination of medical necessity of a request for renewal of a prior authorization for a Lipotropic, Other that was previously approved will take into account whether the beneficiary:

1. Has documentation of tolerability and a positive clinical response demonstrated by lab test results, if appropriate for the diagnosis, since starting the requested medication (e.g., decreased LDL-C, decreased triglycerides, etc.); **AND**
2. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
3. Does not have a contraindication to the prescribed medication; **AND**
4. For a PCSK9 inhibitor, is using the requested PCSK9 inhibitor in addition to **one** of the following:
   a. For treatment of HoFH, standard lipid-lowering treatments as recommended by current consensus guidelines[14]
   b. For treatment of all other conditions, the maximally tolerated dose of the highest-tolerated intensity statin (if clinically appropriate);

   AND

5. For an ACL inhibitor, **all** of the following:
   a. Is prescribed the ACL inhibitor by or in consultation with an appropriate specialist (e.g., cardiologist, endocrinologist, or other provider specializing in lipid disorders),
   b. Is using the requested ACL inhibitor in addition to the maximally tolerated dose of the highest-tolerated intensity statin (if clinically appropriate),
   c. If currently taking simvastatin or pravastatin, is not using the requested ACL inhibitor concomitantly with simvastatin at a dose of greater than 20 mg daily or pravastatin at a dose of greater than 40 mg daily;

   AND

6. For an MTP inhibitor, **both** of the following:
   a. Is prescribed the MTP inhibitor by or in consultation with a cardiologist, endocrinologist, or other provider specializing in lipid disorders

[13] e.g., American Heart Association/American College of Cardiology, American Association of Clinical Endocrinologists/American College of Endocrinology, American Diabetes Association, National Lipid Association, European Society of Cardiology/European Atherosclerosis Society, International Familial Hypercholesterolaemia Foundation, International Atherosclerosis Society

[14] e.g., American Heart Association/American College of Cardiology, American Association of Clinical Endocrinologists/American College of Endocrinology, American Diabetes Association, National Lipid Association, European Society of Cardiology/European Atherosclerosis Society, International Familial Hypercholesterolaemia Foundation, International Atherosclerosis Society

b. Is using the MTP inhibitor in addition to standard lipid-lowering treatments as recommended by current consensus guidelines;[15]

AND

7. For an ANGPTL3 inhibitor, **both** of the following:
   a. Is prescribed the ANGPTL3 inhibitor by or in consultation with a cardiologist, endocrinologist, or other provider specializing in lipid disorders
   b. Is using the ANGPTL3 inhibitor in addition to standard lipid-lowering treatments as recommended by current consensus guidelines;[16]

   AND

8. For all other non-preferred Lipotropics, Other, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Lipotropics, Other approved or medically accepted for the beneficiary's diagnosis.

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a Lipotropic, Other. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

D. Dose and Duration of Therapy

Requests for prior authorization of Lipotropics, Other will be approved as follows:

1. For a PCSK9 inhibitor:
   a. Initial requests will be approved for up to 3 months.
   b. Renewal requests will be approved for up to 12 months.
2. For an ACL inhibitor:
   a. Initial requests will be approved for up to 3 months.
   b. Renewal requests will be approved for up to 12 months.
3. For all other Lipotropics, Other:
   a. Initial requests will be approved for up to 6 months.
   b. Renewal requests will be approved for up to 12 months.

[15] e.g., American Heart Association/American College of Cardiology, American Association of Clinical Endocrinologists/American College of Endocrinology, American Diabetes Association, National Lipid Association, European Society of Cardiology/European Atherosclerosis Society, International Familial Hypercholesterolaemia Foundation, International Atherosclerosis Society
[16] e.g., American Heart Association/American College of Cardiology, American Association of Clinical Endocrinologists/American College of Endocrinology, American Diabetes Association, National Lipid Association, European Society of Cardiology/European Atherosclerosis Society, International Familial Hypercholesterolaemia Foundation, International Atherosclerosis Society

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JUXTAPID (lomitapide) and EVKEEZA (evinacumab) PRIOR AUTHORIZATION FORM

☐New request ☐Renewal request	Total # of pages:_____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested: ☐Juxtapid capsule ☐Evkeeza vial		Strength:
Dose/directions:		Quantity: / Refills:
Diagnosis:		Dx code (*required*):
Is the requested medication prescribed by or in consultation with a cardiologist, endocrinologist, or other lipid disorder specialist?		☐Yes ☐No *If prescriber is not a specialist, submit documentation of consultation.*

INITIAL Requests

Check all options that apply to the beneficiary and *submit documentation for each, including chart notes, test results, and medication history*.

- ☐Diagnosis of homozygous familial hypercholesterolemia (HoFH) supported by medical & family history, cholesterol panel, labs, etc.
- ☐Has documentation of results of a lipid profile within the past 3 months
- ☐History of trial and failure of or a contraindication or an intolerance of the following lipid lowering drug classes at therapeutic doses:
  - ☐bile acid sequestrants (ex. cholestyramine, Welchol) ☐omega-3 fatty acids (ex. Lovaza, Vascepa) ☐statins
  - ☐ezetimibe (Zetia) ☐PCSK9 inhibitor (ex. Praluent, Repatha) ☐other: _____
  - ☐fibrates (ex. fenofibrate, gemfibrozil)
- ☐Will be taking the requested medication in addition to therapeutic doses of agents in the following lipid lowering drug classes:
  - ☐bile acid sequestrants (ex. cholestyramine, Welchol) ☐fibrates (ex. fenofibrate, gemfibrozil) ☐statins
  - ☐ezetimibe (Zetia) ☐omega-3 fatty acids (ex. Lovaza, Vascepa) ☐other: _____
- ☐Is homozygous for LDLR-negative mutations (i.e., has LDLR-negative mutations in both alleles) associated with LDLR activity below 2%
- ☐This request is for JUXTAPID and:
  - ☐Is NOT taking a medication that is a moderate or strong CYP3A4 inhibitor *(submit medication list)*
  - ☐Does not have moderate to severe liver impairment, active liver disease, or unexplained persistent elevations of transaminases

RENEWAL Requests

Check all options that apply to the beneficiary and *submit documentation for each, including chart notes, test results, and medication history*.

- ☐Has a documented decrease in LDL-C since starting the requested medication
- ☐This request is for JUXTAPID and:
  - ☐Is NOT taking a medication that is a moderate or strong CYP3A4 inhibitor *(submit medication list)*
  - ☐Does not have moderate to severe liver impairment, active liver disease, or unexplained persistent elevations of transaminases

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Prescriber Signature:	Date:

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NEXLETOL and NEXLIZET PRIOR AUTHORIZATION FORM

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug & strength requested:	Dose/directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

ALL requests (initial and renewal)

List all lipid-lowering medications and doses the beneficiary will use in conjunction with the requested medication.

Is the medication being prescribed by or in consultation with a cardiologist, endocrinologist, or other lipid disorders specialist?	☐Yes ☐No *Submit documentation of consultation, if applicable.*

All INITIAL requests

Check all of the following that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐Has documentation of results of a lipid profile within the past 3 months
☐Tried and failed maximally tolerated doses of TWO different high-intensity statins (i.e., atorvastatin, rosuvastatin) for at least THREE months each
☐Is unable to tolerate high-intensity statins:
- ☐Has a temporally related intolerance to high-intensity statins (i.e., occurrence of symptoms and/or lab abnormalities upon initiation of a statin, resolution of symptoms and/or lab abnormalities upon discontinuation of a statin, and recurrence of symptoms and/or lab abnormalities after rechallenge with the same statin at the same dose)
- ☐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
- ☐The following conditions associated with statin intolerance were ruled out or addressed:
  - ☐Hypothyroidism
  - ☐Acute or chronic kidney impairment
  - ☐Vitamin D deficiency
  - ☐Obstructive liver disease
  - ☐Drug interactions with statins

☐Has one of the following contraindications to statins:
- ☐Has active liver disease or unexplained persistent elevations in hepatic transaminase levels
- ☐Is pregnant or breastfeeding

☐Tried and failed ezetimibe in combination with the highest-tolerated intensity statin for at least THREE months
☐Has a contraindication or intolerance to ezetimibe
☐Tried and failed or has a contraindication or intolerance to PCSK9 inhibitors (e.g., Praluent, Repatha)

All RENEWAL requests

Did the beneficiary's LDL-C decrease since starting the requested medication?	☐Yes – *submit documentation.* ☐No

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Prescriber Signature:	Date:

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PCSK9 INHIBITORS PRIOR AUTHORIZATION FORM

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:
☐Praluent *(indicate formulation):* ☐pen ☐other: _____
☐Repatha *(indicate formulation):* ☐Pushtronex ☐SureClick ☐syringe ☐other: _____

Strength:	Dose/directions:	Quantity:	Refills:

Diagnosis *(submit documentation)*:

Dx code (*required*):

ALL requests (initial and renewal)

List all lipid-lowering medications and doses the beneficiary will use in conjunction with the requested PCSK9 inhibitor.

All INITIAL requests

Check all of the following that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐Has documentation of results of a lipid profile within the past 3 months
☐Tried and failed maximally tolerated doses of TWO different high-intensity statins (i.e., atorvastatin, rosuvastatin) for at least THREE months each
☐Is unable to tolerate high-intensity statins:
- ☐Has a temporally related intolerance to high-intensity statins (i.e., occurrence of symptoms and/or lab abnormalities upon initiation of a statin, resolution of symptoms and/or lab abnormalities upon discontinuation of a statin, and recurrence of symptoms and/or lab abnormalities after rechallenge with the same statin at the same dose)
- ☐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
- ☐The following conditions associated with statin intolerance were ruled out or addressed:
  - ☐Hypothyroidism
  - ☐Acute or chronic kidney impairment
  - ☐Vitamin D deficiency
  - ☐Obstructive liver disease
  - ☐Drug interactions with statins

☐Has one of the following contraindications to statins:
- ☐Has active liver disease or unexplained persistent elevations in hepatic transaminase levels
- ☐Is pregnant or breastfeeding

☐Tried and failed ezetimibe in combination with the highest-tolerated intensity statin for at least THREE months
☐Has a contraindication or intolerance to ezetimibe

All RENEWAL requests

Did the beneficiary's LDL-C decrease since starting the requested medication?	☐Yes ☐No *Submit documentation.*

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Prescriber Signature:	Date:

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NON-PREFERRED MEDICATION PRIOR AUTHORIZATION FORM *(form effective 01/01/20)*

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/State/Zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

Please refer to https://papdl.com/preferred-drug-list for the list of preferred and non-preferred medications in each Preferred Drug List class.

Non-preferred medication name:		Dosage form:	Strength:
Directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

Has the beneficiary taken the requested non-preferred medication in the past 90 days? *(submit documentation)*..... ☐Yes ☐No

Describe all applicable medical reasons the beneficiary cannot use the preferred medication(s) in the same Preferred Drug List class. *Submit documentation (e.g., recent chart/clinic notes, diagnostic evaluations, lab results, etc.) supporting this non-preferred request.*

☐Treatment failure or inadequate response with preferred medication(s) *(include drug name, dose, and start/stop dates)*:

_____

_____

☐Unacceptable side effects, hypersensitivities, or other intolerances to preferred medication(s) *(include description and drug name(s))*:

_____

_____

☐Contraindication to preferred medication(s) *(include description and drug name(s))*:

_____

_____

☐Unique clinical or age-specific indications supported by FDA approval or medical literature *(describe)*:

_____

_____

☐Absence of preferred medication(s) with appropriate formulation *(list medical reason formulation is required)*:

_____

_____

☐Drug-drug interaction with preferred medication(s) *(describe)*:

_____

_____

☐Other medical reason(s) the beneficiary cannot use the preferred medication(s) *(describe)*:

_____

_____

☐For renewal requests of previously approved medications, submit documentation of tolerability and beneficiary's clinical response.

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Prescriber Signature:	Date: