

Louisiana Medicaid
Heart Disease – Hyperlipidemia – Lipotropics (Other)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request:

- Prior authorization for non-preferred lipotropic (other) agents; **OR**
- Clinical authorization for alirocumab (Praluent®), evolocumab (Repatha®), evinacumab-dgnb (Evkeeza™), inclisiran (Leqvio®), lomitapide (Juxtapid®) and olezarsen (Tryngolza™).

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available [HERE](#).

Approval Criteria for Non-Preferred Lipotropics (Other) Agents (Other than Evkeeza™, Juxtapid®, Leqvio®, Praluent®, Repatha® and Tryngolza™)

- There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- Previous use of a preferred product – **ONE** of the following is required:
 - The recipient has had a *treatment failure* with at least one preferred product; **OR**
 - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
 - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
 - There is *no preferred product that is appropriate* to use for the condition being treated; **OR**
 - The prescriber states that the recipient is currently using the requested medication **AND ONE** of the following applies:
 - There is evidence in pharmacy claims of at least 60 days of the requested medication within the previous 90-day period; **OR**
 - There is evidence in pharmacy claims of less than 60 days of the requested medication **AND** the prescriber states the recipient has been treated with the requested medication in an inpatient facility; **OR**
 - There is evidence in pharmacy claims of less than 60 days of the requested medication **AND** the prescriber has verified that the pharmacy has dispensed at least 60 days of medication (billed to other insurance, and therefore not viewable in pharmacy claims).

Duration of approval for initiation and continuation of therapy: 12 months

Alirocumab (Praluent®)

Approval Criteria for Initiation of Therapy

- The recipient has **ONE** of the following diagnoses:
 - atherosclerotic cardiovascular disease [18 years of age or older]; **OR**
 - primary hyperlipidemia (including heterozygous familial hypercholesterolemia [HeFH]) [18 years of age or older]; **OR**

- homozygous familial hypercholesterolemia (HoFH) [18 years of age or older] **AND** the recipient is currently receiving at least **ONE** low-density lipoprotein-cholesterol (LDL-C) lowering agent, the name of which is **stated on the request; OR**
- heterozygous familial hypercholesterolemia (HeFH) [8 years to less than 18 years of age] **AND** the recipient is currently receiving at least **ONE** low-density lipoprotein-cholesterol (LDL-C) lowering agent, the name of which is **stated on the request; AND**
- The requested medication is prescribed by, or the request states that this medication is being prescribed in consultation with, either a cardiologist or specialist in the treatment of lipid disorders; **AND**
- The recipient has received the maximally-tolerated FDA-approved dose of a statin agent for at least 8 consecutive weeks without adequate response, **OR** has a documented intolerance to, or contraindication to statin agents [the name of the statin agent and date range of treatment are **stated on the request**]; **AND**
- For a non-preferred product, there is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- If the request is for a non-preferred agent - **ONE** of the following is required:
 - The recipient has had a *treatment failure* with at least one preferred product; **OR**
 - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
 - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
 - There is *no preferred product that is appropriate* to use for the condition being treated.

Duration of approval for initiation of therapy: 6 months

Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of approval for continuation of therapy: 12 months

Evinacumab-dgnb (Evkeeza®)

Approval Criteria for Initiation of Therapy

- The recipient is 1 year of age or older on the date of the request; **AND**
- The recipient has a diagnosis of homozygous familial hypercholesterolemia (HoFH); **AND**
- The recipient is currently receiving at least **ONE** low-density lipoprotein-cholesterol (LDL-C) lowering therapy (e.g., statins, ezetimibe, lipoprotein apheresis), the name of which is **stated on the request; AND**
- Evkeeza™ is prescribed by, or the request states that this medication is being prescribed in consultation with, either a cardiologist or specialist in the treatment of lipid disorders; **AND**
- For recipients 7 years of age or older, there is documented failure of, or intolerance to, or contraindication to an adequate trial (8 weeks) of a statin agent [the name of the statin agent and date range of treatment are **stated on the request**]; **AND**

- For a non-preferred product, there is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- If the request is for a non-preferred agent - **ONE** of the following is required:
 - The recipient has had a *treatment failure* with at least one preferred product; **OR**
 - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
 - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
 - There is *no preferred product that is appropriate* to use for the condition being treated.

Duration of approval for initiation of therapy: 6 months

Approval Criteria for Continuation of Therapy

- The recipient is currently receiving at least **ONE** low-density lipoprotein-cholesterol (LDL-C) lowering agent, the name of which is **stated on the request**; **AND**
- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of approval for continuation of therapy: 12 months

Evolocumab Subcutaneous SureClick; Pushtronex; Syringe (Repatha®)

Approval Criteria for Initiation of Therapy

- The recipient has **ONE** of the following [age requirements apply]:
 - increased risk for major adverse cardiovascular (CV) events (CV death, myocardial infarction, stroke, unstable angina requiring hospitalization, or coronary revascularization) [18 years of age or older]; **OR**
 - hypercholesterolemia [18 years of age or older]; **OR**
 - heterozygous familial hypercholesterolemia (HeFH) [10 years of age or older]; **OR**
 - homozygous familial hypercholesterolemia (HoFH) [10 years of age or older]; **AND**
- The requested medication is prescribed by, or the request states that this medication is being prescribed in consultation with, either a cardiologist or specialist in the treatment of lipid disorders; **AND**
- The recipient has received the maximally-tolerated FDA-approved dose of a statin agent for at least 8 consecutive weeks without adequate response, **OR** has a documented intolerance to, or contraindication to statin agents [the name of the statin agent and date range of treatment are **stated on the request**]; **AND**
- For a non-preferred product, there is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- If the request is for a non-preferred agent - **ONE** of the following is required:
 - The recipient has had a *treatment failure* with at least one preferred product; **OR**
 - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**

- The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
- There is *no preferred product that is appropriate* to use for the condition being treated.

Duration of approval for initiation of therapy: 6 months

Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of approval for continuation of therapy: 12 months

Inclisiran (Leqvio®)

Approval Criteria for Initiation of Therapy

- ~~• The recipient is 18 years old or older on the date of the request; **AND**~~
- The recipient has **ONE** of the following [age requirements apply]:
 - hypercholesterolemia [18 years of age or older]; **OR**
 - heterozygous familial hypercholesterolemia (HeFH) [12 years of age or older]; **OR**
 - homozygous familial hypercholesterolemia (HoFH) [12 years to less than 18 years of age];
AND
- ~~• The recipient has a diagnosis of hypercholesterolemia (including heterozygous familial hypercholesterolemia [HeFH]); **AND**~~
- The recipient has received the maximally-tolerated FDA-approved dose of a statin agent for at least 8 consecutive weeks and requires additional lowering of LDL-C, **OR** has a documented intolerance to, or contraindication to statin agents [the name of the statin agent and date range of treatment are **stated on the request**]; **AND**
- The requested medication is prescribed by, or the request states that this medication is being prescribed in consultation with, either a cardiologist or specialist in the treatment of lipid disorders; **AND**
- For a non-preferred product, there is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- If the request is for a non-preferred agent - **ONE** of the following is required:
 - The recipient has had a *treatment failure* with at least one preferred product; **OR**
 - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
 - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
 - There is *no preferred product that is appropriate* to use for the condition being treated.

Duration of approval for initiation of therapy: 6 months

Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that the recipient is established on the medication with evidence

of a positive response to therapy.

Duration of approval for continuation of therapy: 12 months

Lomitapide (Juxtapid®)

Approval Criteria for Initiation of Therapy

- The recipient is ~~2~~18 years of age or older; **AND**
- The recipient has a diagnosis of homozygous familial hypercholesterolemia (HoFH); **AND**
- The recipient is currently receiving at least **ONE** lipid lowering treatment, the name of which is **stated on the request**; **AND**
- Juxtapid® is prescribed by, or the request states that this medication is being prescribed in consultation with, either a cardiologist or specialist in the treatment of lipid disorders; **AND**
- The recipient has a documented failure of, or intolerance to, or contraindication to an adequate trial (8 weeks) of a statin agent [the name of the statin agent and date range of treatment are **stated on the request**]; **AND**
- For a non-preferred product, there is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- If the request is for a non-preferred agent - **ONE** of the following is required:
 - The recipient has had a *treatment failure* with at least one preferred product; **OR**
 - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
 - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
 - There is *no preferred product that is appropriate* to use for the condition being treated.

Duration of approval for initiation of therapy: 6 months

Approval Criteria for Continuation of Therapy

- The recipient is currently receiving at least **ONE** lipid lowering treatment, the name of which is **stated on the request**; **AND**
- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of approval for continuation of therapy: 12 months

Olezarsen (Tryngolza™)

Approval Criteria for Initiation of Therapy

- The recipient is 18 years of age or older on the date of the request; **AND**
- The recipient has a fasting triglyceride level ≥ 880 mg/dL; **AND**
- The recipient has a diagnosis of familial chylomicronemia syndrome (FCS); **AND**

- The recipient has received genetic testing and meets **ONE** of the following:
 - A positive genetic test confirming the diagnosis of FCS; **OR**
 - An indeterminate genetic test and the recipient has **ONE** of the following:
 - Familial chylomicronemia syndrome score ≥ 10 ; **OR**
 - North American familial chylomicronemia syndrome score ≥ 45 ; **OR**
 - History of recurrent abdominal pain or acute pancreatitis; **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a cardiologist, an endocrinologist, or a specialist experienced in treatment of FCS; **AND**
- The prescriber **states on the request** that there are no known secondary causes for the recipient's severe hypertriglyceridemia (sHTG); **AND**
- The prescriber **states on the request** that the requested medication will be used concomitantly with dietary management of FCS, including a low-fat diet.

Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy with improvement in fasting triglyceride (TG) levels.

Duration of approval for initiation and continuation of therapy: 12 months

References

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Revision / Date	Implementation Date
Single PDL Implementation	May 2019
Updated diagnosis for Praluent®, added Evkeeza™, updated references, removed defining parameters for diagnosis, formatting changes / May 2021	October 2021
Formatting changes, removed quantity limits for Praluent®, Repatha®, and Juxtapid® / August 2021	January 2022
Updated age indication for Repatha® / October 2021	April 2022
Clarified concurrent use requirements for Juxtapid® / December 2021	April 2022
Added Leqvio®, formatting changes, updated references / February 2022	July 2022
Modified statin previous use requirement for Evkeeza™, Juxtapid®, Leqvio®, Praluent®, and Repatha® / May 2023	July 2023
Modified age criteria for Evkeeza™, updated references / May 2023	October 2023
Updated diagnosis for Leqvio®, updated references / July 2023	January 2024
Updated age indication for Praluent®, formatting changes, updated references / March 2024	October 2024

Added clinical authorization for Tryngolza™, updated references / June 2025	August 2025
Removed adjunct to statin therapy criterion for Leqvio® and updated indications, updated indications for Repatha®, expanded age indication for Evkeeza®, updated references / September 2025	April 2026
<u>Updated diagnosis for Leqvio®, modified age criteria for Juxtapid®, updated references / February 2026</u>	<u>July 2026</u>