Mass General Brigham
Health Plan

Lipid Lowering Agents
Effective 10/02/2023

Plan	☒ MassHealth ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☒ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☒ Medical Benefit (NLX)		
Specialty Limitations	N/A		
Contact Information	**Specialty Medications**		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions	Evkeeza is available under medical benefit only. Leqvio is available under pharmacy and medical benefits.		

Overview

No PA	Drugs that require PA
Fibric Acid Derivatives	
Antara® # (fenofibrate 30 mg, 90 mg capsule) fenofibric acid tablet Lipofen® (fenofibrate 50 mg, 150 mg capsule) ‡ fenofibrate capsule, 54 mg and 160 mg tablet Lopid® # (gemfibrozil) Tricor® # (fenofibrate 48 mg, 145 mg tablet) Trilipix® # (fenofibric acid capsule)	Fenoglide® (fenofibrate 40 mg, 120 mg tablet) (QL > 1 unit/day) †
PCSK9 Inhibitors	
	Praluent® (alirocumab) Repatha® (evolocumab)
Statins	
	Altoprev® (lovastatin extended-release) (QL > 1.5 units/day for 20 mg and 40 mg; QL > 1 unit/day for 60 mg) Atorvaliq (atorvastatin suspension) Crestor® # (rosuvastatin 5 mg, 10 mg, 20 mg) >1.5 units/day† Crestor® # (rosuvastatin 40 mg) > 1 unit/day † Ezallor® (rosuvastatin sprinkle capsule) > 1 unit/day Flolipid® (simvastatin suspension) §

	fluvastatin (QL > 1.5 units/day for 20 mg; QL > 2 units/day for 40 mg) † Lescol XL® (Fluvastatin extended-release) (QL > 1 unit/day) † Lipitor® # (atorvastatin 10 mg, 20 mg, 40 mg) > 1.5 units/day † Lipitor® # (atorvastatin 80 mg) > 1 unit/day † Livalo® (pitavastatin calcium) (QL > 1.5 units/day for 1 mg, 2 mg; QL > 1 unit/day for 4 mg) lovastatin 10 mg, 20 mg >1.5 units/day lovastatin 40 mg > 2 units/day pravastatin 10 mg, 20 mg, 40 mg >1.5 units/day pravastatin 80 mg > 1 unit/day Zocor® # (simvastatin 5 mg, 10 mg, 20 mg, 40 mg) > 1.5 units/day † Zocor® # (simvastatin 80 mg) > 1 unit/day † Zypitamag® (pitavastatin magnesium) (QL > 1.5 units/day for 2 mg; QL > 1 unit/day for 4 mg
Combination Lipid Lowering Agents	
	Caduet® (amlodipine/atorvastatin) (QL > 1 unit/day) † Roszet® (rosuvastatin/ezetimibe) §‡ Vytorin® # (ezetimibe/simvastatin) > 1 unit/day†
Miscellaneous Lipid Lowering Agents	
cholestyramine/aspartame †† cholestyramine/sucrose †† Colestid® # (colestipol) Lovaza® # (omega-3 acid ethyl esters) Niaspan® # (niacin extended-release tablet) vitamin B-3 (niacin) * Welchol® # (colesevelam) Zetia® # (ezetimibe)	Evkeeza® (evinacumab-dgnb) [MB] Leqvio® (inclisiran) [DUAL] Juxtapid® (lomitapide) Nexletol® (bempedoic acid) (QL > 1 unit/day) Nexlizet® (bempedoic acid/ezetimibe) (QL > 1 unit/day) Vascepa® (icosapent ethyl) † [BP]

#This is a brand-name drug with FDA "A"-rated generic equivalents. PA is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalents

[BP] Brand Preferred over generic equivalents. In general, requires a trial of the preferred drug or clinical rationale for prescribing the non-preferred drug generic equivalent.

MB This drug is available through the health care professional who administers the drug or in an outpatient or inpatient hospital setting. The Plan does not pay for this drug to be dispensed through the retail pharmacy.

DUAL This drug is available through both pharmacy and medical benefits

*The generic OTC and, if any, generic prescription versions of the drug are payable without prior authorization

†Available as an A-rated generic. Both brand and A-rated generic require PA.

‡Available as an authorized generic

†† A branded generic(s) is available in this formulation.

§This agent does not participate in federal rebate

Approvable Diagnosis:

- Primary hyperlipidemia
- Primary prevention of cardiovascular events
- Hypercholesterolemia in a member with a previous history of any cardiovascular event

- HeFH
- HoFH
- Primary dysbetaliproteinemia
- Hypertriglyceridemia

Coverage Guidelines
Authorization may be reviewed on a case by case basis for members who are new to the plan currently receiving treatment with requested medication excluding when the product is obtained as samples or via manufacturer's patient assistance programs.
OR
Authorization may be granted for members when all the following criteria are met, and documentation is provided:

Fenoglide® (fenofibrate 40 mg, 120 mg tablet)
ALL of the following:
1. Diagnosis of hypertriglyceridemia, hypercholesterolemia, or mixed dyslipidemia
2. Medical records documenting an inadequate response or adverse reaction to a therapeutically equivalent fenofibrate formulation available without prior authorization
3. **ONE** of the following:
    a. Requested quantity is ≤ 1 unit/day
    b. Medical necessity for the requested agent above quantity limits

Praluent® (alirocumab)
Repatha® (evolocumab)
ALL of the following:
1. **ONE** of the following:
    a. Praluent: Member is ≥18 years of age
    b. Repatha: Member has a diagnosis of HeFH or HoFH and is ≥ 10 years of age OR member is ≥18 years of age
2. Diagnosis is hypercholesterolemia with **ONE** of the following:
    a. For members with a diagnosis of HeFH or HoFH, current LDL-C is ≥70 mg/dL
    b. For members with a previous history of a cardiovascular event (with or without HeFH or HoFH), current LDL-C is ≥55 mg/dL
    c. For members with primary hyperlipidemia (without a history of a cardiovascular event and/or HeFH/HoFH), baseline LDL-C is ≥190 mg/dL, and current LDL-C is ≥70 mg/dL
3. **ONE** of the following*:
    a. Paid claims or physician attestation of inadequate response (defined as ≥ the last 3 months) to a high intensity statin in combination with ezetimibe
    b. Adverse reaction or contraindication to ezetimibe‡ AND inadequate response (defined as ≥ the last 3 months) to high intensity statin monotherapy
    c. Adverse reaction to ONE high intensity statin or contraindication to ALL high intensity statins
4. Appropriate dosing
5. **ONE** of the following:
    a. Praluent: Requested quantity is 2 pens or syringes/28 days
    b. Repatha: Requested quantity is 2 autoinjectors or syringes/28 days or 1 to 2 on-body infuser systems/28 days

**If the prescriber documents that the member has experienced an adverse reaction to a high intensity statin or has a contraindication to high intensity statins, requests may be approved without the requirement for ezetimibe monotherapy*
‡*Please see Appendix I: Special Considerations in Lipid Lowering Therapy for requests that document that less costly trials will be associated with inadequate lipid lowering.*

Caduet® (amlodipine/atorvastatin)
ALL of the following:
1. **ONE** of the approvable diagnoses (list above)
2. Medical necessity for use of the combination product instead of the commercially available separate agents
3. **ONE** of the following:
    a. Requested quantity is ≤ 1 tablet/day
    b. Medical necessity for the requested agent above quantity limits (See Appendix II: Requests above the quantity limit)
    c. If the request is above the maximum, FDA-approved dose, inadequate response (defined as ≥ the last 3 months) to atorvastatin 80 mg daily

Altoprev® (lovastatin extended-release)
fluvastatin
Lescol XL® (fluvastatin extended-release)
Livalo® (pitavastatin calcium)
Zypitamag® (pitavastatin magnesium)
ALL of the following:
1. **ONE** of the approvable diagnoses (list above)
2. **ONE** of the following:
    a. Paid claims or physician attestation of inadequate response (defined as ≥ the last 3 months) or an adverse reaction to ONE or contraindication to ALL high intensity statins
    b. A well-defined clinical rationale for not trying a high intensity statin
3. **ONE** of the following:
    a. Request is within quantity limit for strength requested
    b. Medical necessity for the requested agent above quantity limits (See Appendix II: Requests above the quantity limit)
    c. If the request is above the maximum, FDA-approved dose, inadequate response (defined as ≥ the last 3 months) to atorvastatin 80 mg daily

Above Quantity Limits
Crestor® (rosuvastatin)
Lipitor® (atorvastatin)
lovastatin
pravastatin
Vytorin® (ezetimibe/simvastatin)
Zocor® (simvastatin)
ALL of the following:
1. **ONE** of the approvable diagnoses (list above)
2. Medical necessity for the requested agent above quantity limits (See Appendix II: Requests above the quantity limit)

Atorvaliq® (atorvastatin suspension)
Ezallor® (rosuvastatin sprinkle capsule)
Flolipid® (simvastatin suspension)
ALL of the following:

1. **ONE** of the approvable diagnoses (list above)
2. Medical necessity for the requested formulation as noted by one of the following:
    a. Member has severe dysphagia AND is currently only utilizing formulations that can easily be swallowed (e.g., solutions, suspensions, films, or dispersible tablets)
    b. Member utilizes tube feeding (G-tube/J-tube)
    c. Member is < 13 years of age
3. Appropriate dosing
4. For Ezallor, requested quantity is ≤ one sprinkle capsule/day
5. For Atorvaliq, clinical rationale for the use of the requested agent instead of Ezallor
6. For FloLipid, requests must meet the above criteria and the prescriber must submit documentation of trials of alternatives with rebate or clinical rationale for the use of a non-rebate product (as per the Non-FDA approved and Non-rebate Medications guideline)

Roszet® (rosuvastatin/ ezetimibe)
ALL of the following:

1. Diagnosis of hypercholesterolemia or HoFH
2. Clinical rationale for use of the combination product over the commercially available separate agents
3. Request is within quantity limit of 1 unit/day
   Requests must meet the above criteria and the prescriber must submit documentation of trials of alternatives with rebate or clinical rationale for the use of a non-rebate product (as per the Non-FDA approved and Non-rebate Medications guideline)

Evkeeza® (evinacumab-dgnb) [MB]
ALL of the following:

1. Diagnosis of HoFH confirmed by **ONE** of the following:
    a. Laboratory test confirming genetic mutation associated with HoFH including low density lipoprotein receptor (LDLR) mutations, PCSK9 mutations and familial defective apoB mutations
    b. **BOTH** of the following:
        i. Baseline LDL-C ≥ 400 mg/dL
        ii. Current LDL-C ≥ 100 mg/dL
    c. **ONE** of the following:
        i. Member had evidence of xanthoma before 10 years of age
        ii. Evidence of HeFH in both parents
2. Member is ≥ 5 years of age
3. Prescriber is a specialist (e.g. cardiologist, vascular neurologist, lipid lowering specialist, endocrinologist) or consultation notes from a specialist regarding the use of the agent are provided
4. **ONE** of the following:
    a. Agent to be used as add-on therapy with a high-intensity statin, ezetimibe, and PCSK9 inhibitor
    b. Contraindication or other well-defined clinical rationale for omitting one or more of the standard lipid-lowering therapies: statin, ezetimibe, and PCSK9 inhibitors
5. Member's current weight (use to verify correct dosing)
6. Appropriate dosing

Leqvio® (inclisiran)

ALL of the following:

1. Diagnosis is hypercholesterolemia with **ONE** of the following:
    a. For members with a diagnosis of HeFH, current LDL-C is ≥70 mg/dL
    b. For members with a previous history of a cardiovascular event (with or without HeFH), current LDL-C is ≥55 mg/dL
2. Member is ≥18 years of age
3. Prescriber is a specialist (e.g. cardiologist, vascular neurologist, lipid lowering specialist, endocrinologist) or consultation notes from a specialist regarding the use of the agent are provided
4. Paid claims or physician attestation of inadequate response (defined as ≥ the last 3 months) or adverse reaction to **ONE** or contraindication to **BOTH** of the following*:
    a. Praluent® (alirocumab)
    b. Repatha® (evolocumab)
5. **ONE** of the following†:
    a. Paid claims or physician attestation of inadequate response (defined as ≥ the last 3 months) to combination therapy with a high intensity statin and ezetimibe
    b. Adverse reaction or contraindication to ezetimibe AND inadequate response (defined as ≥ the last 3 months) to high intensity statin monotherapy
    c. Adverse reaction to ONE high intensity statin or contraindication to ALL high intensity statins
6. Appropriate dosing

*Requests looking to bypass the required trial with Praluent®(alirocumab) or Repatha®(evolocumab) may be approved if the prescriber documents concerns with the member using self-injections (due to non-adherence or low health literacy)

† If the prescriber documents that the member has experienced an adverse reaction to a high intensity statin or has a contraindication to high intensity statins, requests may be approved without the requirement for ezetimibe monotherapy

Juxtapid® (lomitapide)

ALL of the following:

1. Diagnosis of HoFH confirmed by **ONE** of the following:
    a. Laboratory test confirming genetic mutation associated with HoFH including low density lipoprotein receptor (LDLR) mutations, PCSK9 mutations and familial defective apoB mutations
    b. **BOTH** of the following:
        i. Baseline LDL-C ≥ 400 mg/dL
        ii. Current LDL-C ≥ 100 mg/dL
    c. **ONE** of the following:
        i. Member had evidence of xanthoma before 10 years of age
        ii. Evidence of HeFH in both parents
2. Member is ≥ 18 years of age
3. Prescriber is a specialist (e.g. cardiologist, vascular neurologist, lipid lowering specialist, endocrinologist) or consultation notes from a specialist regarding the use of the agent are provided
4. **ONE** of the following:
    a. Paid claims or physician attestation of inadequate response (defined as ≥ the last 3 months) or adverse reaction to ONE or contraindication to ALL high intensity statins
    b. Clinical rationale for not trying a high intensity statin
5. **ONE** of the following:
    a. Agent to be used as add-on therapy with a high-intensity statin
    b. Contraindication to statin therapy

6. Physician attestation of inadequate response or adverse reaction to **ONE** additional non-statin lipid lowering agent or contraindication to ALL non-statin lipid lowering agents

Nexletol® (bempedoic acid)
Nexlizet® (bempedoic acid/ezetimibe)
ALL of the following:

1. Diagnosis of hypercholesterolemia with ONE of the following:
    a. For members with a diagnosis of HeFH, current LDL-C is ≥70 mg/dL
    b. For members with a previous history of a cardiovascular event (with or without HeFH or HoFH), current LDL-C is ≥55 mg/dL
2. Member is ≥ 18 years of age
3. Prescriber is a specialist (e.g. cardiologist, vascular neurologist, lipid lowering specialist, endocrinologist) or consultation notes from a specialist regarding the use of the agent are provided
4. **ONE** of the following*:
    a. Paid claims or physician attestation of inadequate response (defined as ≥ the last 3 months) to combination therapy with a high intensity statin and ezetimibe
    b. Adverse reaction or contraindication to ezetimibe AND inadequate response (defined as ≥ the last 3 months) to high intensity statin monotherapy
    c. Adverse reaction to ONE high intensity statin or contraindication to ALL high intensity statins
5. Requested quantity is ≤ 1 tablet/day

*If the prescriber documents that the member has experienced an adverse reaction to a high intensity statin or has a contraindication to high intensity statins, requests may be approved without the requirement for ezetimibe monotherapy

Vascepa® (icosapent ethyl)[BP]
ONE of the following:

1. Diagnosis of hypertriglyceridemia (not inclusive of those with established cardiovascular disease or diabetes mellitus and cardiovascular risk factors)
    a. Triglyceride level ≥ 500 mg/dL
    b. Paid claims or physician attestation of inadequate response, adverse reaction or contraindication (e.g., elevated LDL levels (≥ 100 mg/dL) to omega-3 acid ethyl esters
    c. Paid claims or physician attestation of inadequate response, adverse reaction or contraindication to a fibric acid derivative (i.e., fenofibrate or gemfibrozil)
    d. **ONE** of the following:
        i. For icosapent ethyl 1 g capsule, requested quantity is ≤ 4 capsules/day
        ii. For icosapent ethyl 0.5 g capsule, requested quantity is ≤ 8 capsules/day
        iii. Medical necessity for the requested agent above quantity limits (See Appendix II: Requests above the quantity limit)
2. Diagnosis of cardiovascular risk reduction
    a. **ONE** of the following:
        i. Member has established cardiovascular disease (e.g., prior MI, hospitalization for high-risk NSTE-ACS cerebrovascular or carotid disease: prior ischemic stroke, carotid artery disease, PAD)
        ii. Member has diabetes mellitus with at least one risk factor for CVD (e.g. age [women ≥ 65 years, men ≥ 55 years], smoker, HTN, low HDL-C [≤ 40 mg/dL for men and ≤ 50 mg/dL for women], renal dysfunction [CrCl >30 and < 60 mL/min], retinopathy, micro- or macroalbuminuria, high-sensitivity C-reactive protein (hs-CRP) >3.0 mg/dL, or ankle-brachial index < 0.9 without symptoms of intermittent claudication)

b. Triglyceride level ≥ 135 mg/dL
c. **ONE** of the following:
    i. Requested agent will be used in combination with a statin
    ii. Clinical rationale why member cannot take a statin
d. **ONE** of the following:
    i. For icosapent ethyl 1 gm capsule, requested quantity is ≤ 4 capsules/day
    ii. For icosapent ethyl 0.5 gm capsule, requested quantity is ≤ 8 capsules/day
    iii. Medical necessity for the requested agent above quantity limits (See Appendix II: Requests above the quantity limit)

Continuation of Therapy
Reauthorization should be reviewed for the following information:

Atorvaliq, Ezallor, FloLipid:
Prescriber must provide documentation of continued medical necessity for the requested formulation instead of tablets as noted by **ONE** of the following:
a. Member has severe dysphagia AND is currently utilizing only formulations that can easily be swallowed (e.g., solutions, suspensions, films, or dispersible tablets)
b. Member utilizes tube feeding (G-tube/J-tube)
c. Member is <13 years of age

Evkeeza® (evinacumab-dgnb)
1. **ONE** of the following:
    a. Decrease in LDL-C from baseline and the member appears to be adherent to the regimen.
    b. Decrease in LDL-C from baseline and evidence of non-adherence to one or more agent(s) in the regimen.
2. Updated member weight (use to verify correct dosing; may take this information over the phone if missing on PA request)

Leqvio® (inclisiran)
1. Member appears to be adherent to Leqvio®, statin and/or ezetimibe therapy (consistent with regimen noted on initial approval) (at least 60 days of therapy within the last 90 days for the statin and ezetimibe)
2. **ONE** of the following:
    a. Decrease in LDL-C from baseline and the member appears to be adherent to the regimen.
    b. Decrease in LDL-C from baseline and evidence of non-adherence.
    c. If there is no decrease or an increase in LDL-C, or if an updated LDL-C is not provided and there is evidence of non-adherence.

PCSK9 Inhibitors (Praluent®, Repatha®)
Prescriber must provide documentation of a positive response to therapy.

All Other Agents:
Reauthorization by prescriber will infer a positive response to therapy.

Limitations
1. Initial approvals will be granted for the following:
    a. PCSK9 Inhibitors (Praluent®, Repatha®), Evkeeza® and Leqvio®: 6 months

b. All other agents: 1 year

2. Reauthorizations will be granted for the following:
    a. Evkeeza® and Leqvio®:
        i. Decrease in LDL-C from baseline and member is adherent: 12 months
        ii. Decrease in LDL-C from baseline and non-adherence: 6 months
        iii. No decrease or an increase in LDL-C or updated LDL-C not provided and non-adherence: 6 months
    b. All other agents: 1 year
3. **Requests for Brand Name when generic is preferred:** In addition to any prior authorization requirements that may be listed above, if an A-rated generic equivalent is available, such prior authorization requests require medical records documenting an allergic response, adverse reaction, or inadequate response to the generic equivalent drug (history of allergic reaction to the inactive ingredients used in the manufacturing process of a certain drug is acceptable).
4. **Requests for generic when Brand Name is preferred:** There are some drugs for which the Plan has determined it will be cost effective to prefer the use of the Brand Name formulation. In this case, the generic equivalent formulation is considered non-preferred and requires prior authorization. These requests require medical records documenting an allergic response, adverse reaction, or inadequate response to the Brand Name formulation. For the most up to date list of drugs where the Brand Name formulation is preferred, see the MassHealth Brand Name Preferred Over Generic Drug List (BOGL) at www.mass.gov/druglist.
5. The following quantity limits apply:

Fenoglide (fenofibrate 40 mg, 120 mg tablet)	30 tablets per 30 days
Praluent (alirocumab)	2 pens or syringes per 28 days
Repatha (evolocumab)	2 autoinjectors or syringes per 28 days
Altoprev (lovastatin extended-release)	20 mg, 40 mg: 45 capsules per 30 days 60 mg: 30 capsules per 30 days
Crestor (rosuvastatin)	5 mg, 10 mg, 20 mg: 45 tablets per 30 days 40 mg: 30 tablets per 30 days
Ezallor (rosuvastatin sprinkle capsule)	30 capsules per 30 days
fluvastatin	20 mg: 45 capsules per 30 days 40 mg: 60 capsules per 30 days
Lescol XL® (fluvastatin extended-release)	30 capsules per 30 days
Livalo (pitavastatin calcium)	1 mg, 2 mg: 45 tablets per 30 days 4 mg: 30 tablets per 30 days
Lipitor (atorvastatin)	10 mg, 20 mg, 40 mg: 45 tablets per 30 days 80 mg: 30 tablets per 30 days
Livalo (pitavastatin calcium)	1 mg, 2 mg: 45 tablets per 30 days 4 mg: 30 tablets per 30 days
lovastatin	10 mg, 20 mg: 45 tablets per 30 days 40 mg: 60 tablets er 30 days
pravastatin	10 mg, 20 mg, 40 mg: 45 tablets per 30 days 80 mg: 30 tablets per 30 days
Zocor (simvastatin)	5 mg, 10 mg, 20 mg, 40 mg: 45 tablets per 30 days 80 mg: 30 tablets per 30 days
Zypitamag (pitavastatin magnesium)	2 mg: 45 tablets per 30 days 4 mg: 30 tablets per 30 days

Caduet (amlodipine/atorvastatin)	30 tablets per 30 days
Vytorin (ezetimibe/simvastatin)	30 tablets per 30 days
Nexletol (bempedoic acid)	30 tablets per 30 days
Nexlizet (bempedoic acid/ezetimibe)	30 tablets per 30 days

Appendix

I. Special Considerations in Lipid Lowering Therapy

Contraindication to Statin Therapy
The following should be considered for **approval** when reviewing requests: • Elevated serum transaminases with statin use • Elevated baseline serum transaminases (due to liver disease or other etiology)   ○ All statins are cautioned in patients with liver disease; however, pravastatin has been studied in this population and is generally recommended at low doses

II. Requests above the quantity limit

Quantity limits should allow for the use of most commonly requested doses that are not commercially available. For statin therapy, if the requested dose is above the FDA-approved limits listed below, then an atorvastatin trial is required at an appropriate dose (80 mg) and duration (3 months).

Drug	Maximum FDA-Approved Dose†
Statins	
Altoprev® 20 mg, 40 mg, 60 mg (lovastatin extended-release)	60 mg/day
Crestor® 5 mg, 10 mg, 20 mg, 40 mg (rosuvastatin)	40 mg/day
Ezallor® 5 mg, 10 mg, 20 mg, 40 mg (rosuvastatin sprinkle capsule)	40 mg/day
Lescol® 20 mg, 40 mg (fluvastatin)	80 mg/day
Lescol XL® 80 mg (fluvastatin extended-release)	80 mg/day
Livalo® 1 mg, 2 mg, 4 mg (pitavastatin)	4 mg/day
Lipitor® 10 mg, 20 mg, 40 mg, 80mg (atorvastatin)	80 mg/day
lovastatin 10 mg, 20 mg, 40 mg	80 mg/day
pravastatin10 mg, 20 mg, 40 mg 80 mg	80 mg/day
Roszet® 5 mg/10 mg, 10 mg/10 mg, 20 mg/10 mg, 40 mg/10 mg. (rosuvastatin/ezetimibe)	40 mg/10 mg/day
Vytorin® 10/10 mg, 10/20 mg, 10/40 mg, 10/80 mg (ezetimibe/simvastatin)	10 mg/80 mg/day
Zocor® 5 mg,10 mg, 20 mg, 40 mg, 80 mg (simvastatin)	80 mg/day
Zypitamag® 2 mg, 4 mg (pitavastatin)	4 mg/day
Other Agents	
Fenoglide® 40 mg, 120 mg (fenofibrate)	120 mg/day
Vascepa® 0.5 g, 1 g (icosapent ethyl)	4 g/day

†Doses that are not available commercially are bolded.

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Review History

02/08/2023 - Reviewed and created for Feb P&T; matched MH UPPL criteria to be in compliance with Masshealth unified formulary requirements. Criteria was named as Lipid Lowering Agents. Note: Praluent and Repatha was combined to this criteria. Effective 4/1/23.
07/12/23 – Reviewed and updated for P&T. Formatting updates to drug table. Clarified approvable diagnoses. Praluent and Repatha criteria updated to become less restrictive. Appendix criteria for special populations who are statin intolerant was removed and now combined with its respective criteria. Low cost alternative trials language have been simplified throughout the policy. Praluent and Repatha trial may be bypassed for Leqvio if there are concerns with member using self injections. Caduet®(amlodipine/atorvastatin) was updated to only require medical necessity for use of the combination product instead of the commercially available separate agents. Evkeeza had an age expansion to members aged 5 and older. New drug, Atorvaliq, was added. Brand preferred and mandatory generic language was added under Limitations. Effective 7/31/23
09/13/23 – Reviewed and updated for P&T. Leqvio has been added to pharmacy benefit with PA and will remain on medical benefit with PA. Effective 10/2/23