

UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2026 P 1527-1
Program	Prior Authorization/Notification
Medication	Lerochol® (lerodalcibep-liga)*
P&T Approval Date	7/2026
Effective Date	10/1/2026

1. Background:

Lerochol (lerodalcibep-liga) is a proprotein convertase subtilisin kexin type 9 (PCSK9) inhibitor indicated as an adjunct to diet and exercise: to reduce low-density lipoprotein cholesterol (LDL-C) in adults with hypercholesterolemia, including heterozygous familial hypercholesterolemia (HeFH).

2. Coverage Criteria^a:

A. Initial Authorization

1. **Lerochol*** will be approved based on **all** of the following criteria:

a. **One** of the following diagnoses:

(1) Primary hyperlipidemia

-OR-

(2) Heterozygous familial hypercholesterolemia (HeFH)

-OR-

(3) Atherosclerotic cardiovascular disease (ASCVD) (e.g., acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack, or peripheral arterial disease presumed to be of atherosclerotic origin)

-AND-

b. Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Praluent (alirocumab), Repatha (evolocumab)]

-AND-

c. Not used in combination with Leqvio (inclisiran)

Authorization will be issued for 12 months.

B. Reauthorization

1. **Lerochol*** will be approved based on **all** of the following criteria:

- a. Documentation of positive clinical response to Lerochol* therapy

-AND-

- b. Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Praluent (alirocumab), Repatha (evolocumab)]

-AND-

- c. Not used in combination with Leqvio (inclisiran)

Authorization will be issued for 12 months.

^a State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

*Lerochol is typically excluded from coverage. Tried/Failed criteria may be in place. Please refer to plan specifics to determine exclusion status.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

4. References:

- Lerochol [package insert]. Cincinnati, OH: LIB Therapeutics, Inc.; December 2025.

Program	Prior Authorization/Notification - Lerochol® (lerodalcibep-liga)*
Change Control	
7/2026	New program.