

Nexletol® and Nexlizet® Prior Authorization Form
(Bempedoic Acid and Bempedoic Acid/Ezetimibe)**Member Name:** _____ **Date of Birth:** _____ **Member ID#:** _____**Drug Information****Pharmacy billing (NDC:** _____ **) Fill Date:** _____**Dose:** _____ **Regimen:** _____ **Quantity:** _____ **Day Supply:** _____**Pharmacy Information****Pharmacy NPI:** _____ **Pharmacy Name:** _____**Pharmacy Phone:** _____ **Pharmacy Fax:** _____**Prescriber Information****Prescriber NPI:** _____ **Prescriber Name:** _____**Prescriber Phone:** _____ **Prescriber Fax:** _____ **Specialty:** _____**Criteria****For Initial Authorization (Initial approval will be for the duration of 3 months):**

1. Please indicate member's diagnosis:

- Heterozygous familial hypercholesterolemia (HeFH)** confirmed by 1 or more of the following:
 - Documented functional mutation(s) in low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality via genetic testing (*results of genetic testing must be submitted*)
 - Pre-treatment total cholesterol >290mg/dL or LDL-cholesterol (LDL-C) >190mg/dL
 - History of tendon xanthomas in either the member, first degree relative, or second degree relative
 - Dutch Lipid Clinic Network Criteria score of >8
- Primary hyperlipidemia**
 - Untreated LDL-C level \geq 190mg/dL
 - Current LDL-C level \geq 100mg/dL
- To reduce the risk of major adverse cardiovascular (CV) events (CV death, myocardial infarction, stroke, and coronary revascularization) in adults at increased risk for these events who are unable to take recommended statin therapy. Please provide supporting diagnoses/conditions/risk factors signifying increased risk of major adverse CV events:** _____

2. Will Nexletol® or Nexlizet® be used as an adjunct to diet and exercise, in combination with other low-density lipoprotein cholesterol (LDL-C) lowering therapies or alone when concomitant LDL-C lowering therapies are not possible to reduce LDL-C? Yes ___ No ___

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PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4**CONFIDENTIALITY NOTICE**

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Nexletol® and Nexlizet® Prior Authorization Form
(Bempedoic Acid and Bempedoic Acid/Ezetimibe)

Member Name: _____ **Date of Birth:** _____ **Member ID#:** _____

Criteria

For Initial Authorization: (continued)

3. Please specify the member's current statin therapy:

a. Has the member been on a stable dose of statin therapy for at least 4 weeks? Yes ___ No ___

b. If yes, please provide the following:

i. Medication/strength: _____ Dosing regimen: _____

Duration of treatment: _____ Reason for discontinuation: _____

c. Please provide member's LDL-C level following 4 weeks of statin therapy: _____

d. Is the member taking simvastatin at doses greater than 20mg? Yes ___ No ___

e. Is the member taking pravastatin at doses greater than 40mg? Yes ___ No ___

4. If the member has **not** been on a stable dose of statin therapy for at least 4 weeks, is the member intolerant to statin therapy? Yes ___ No ___

a. If yes, please indicate 1 of the following:

Rhabdomyolysis - creatine kinase (CK) labs verifying this diagnosis must be provided.

An FDA labeled contraindication to all statins. Provide contraindication: _____

Documented intolerance to at least 2 different statins at lower doses or at intermittent dosing:

Please provide all of the following:

1) Medication/strength: _____ Dosing regimen: _____

Duration of treatment: _____ Reason for discontinuation: _____

2) Medication/strength: _____ Dosing regimen: _____

Duration of treatment: _____ Reason for discontinuation: _____

5. Member's baseline LDL-C: _____ Current LDL-C: _____ Goal LDL-C: _____

For Continued Authorization:

1. Has member been compliant with Nexletol® or Nexlizet® treatment? Yes ___ No ___

2. Has Nexletol® or Nexlizet® treatment been effective for this member? Yes ___ No ___

3. Please provide a recent LDL-C level for this member: _____ Date taken: _____

Additional information: _____

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Prescriber Signature: _____ **Date:** _____

By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

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