AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Nexletol and Nexlizet

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity per 30 days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days

Clinical Information

Criteria for Initial Coverage of Nexletol (questions 1-5) and Nexlizet (questions 1-7):

1. Is the recipient at least 18 years old or older? Yes___ No___
2. Has the beneficiary been diagnosed with heterozygous familial hypercholesterolemia (HeFH) or established atherosclerotic cardiovascular disease (ASCVD) defined as acute coronary syndromes, or a history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack, or peripheral arterial disease of atherosclerotic origin? Yes___ No___
3. Has the beneficiary failed to achieve a target LDL-C (at least 50% reduction from baseline OR if no baseline is available: <70 mg/dL for beneficiaries with ASCVD and <100 mg /dL for beneficiaries with HeFH, and no history of ASCVD) despite physician attestation that the beneficiary is adherent to maximally-tolerated doses of statins for at least 90 days duration prior to the lipid panel demonstrating suboptimal reduction? Yes___ No___
4. Is therapy being used in conjunction with maximally-tolerated doses of a statin? Yes___ No___
5. Will therapy NOT be used with concurrent doses of simvastatin > 20mg or pravastatin > 40mg? Yes___ No___

For Nexlizet, answer 1-5 above and 6-7 below:

6. For **NEXLIZET** - Does the beneficiary have a hypersensitivity to ezetimibe (Zetia®)? Yes___ No___
7. Will **NEXLIZET** be used with concurrent fibrate therapy (excluding fenofibrate)? Yes___ No___

Continuation of Coverage for Nexletol and Nexlizet:

8. Does the beneficiary continue to meet the initial criteria above? Yes___ No___
9. Is the beneficiary absent of unacceptable toxicity from therapy? (Examples of unacceptable toxicity include the following: hyperuricemia, tendon rupture) Yes___ No___
10. Does laboratory analysis demonstrate a reduction in LDL-C when compared to the baseline values (prior to initiating bempedoic acid or bempedoic acid/ezetimibe)? Yes___ No___

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406