OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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

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 ≥190mg/dL
     - ☐ Current LDL-C level ≥100mg/dL
   - ☐ **To reduce the risk of myocardial infarction and coronary revascularization in those unable to take recommended statin therapy with 1 of the following:** (select one and provide supporting diagnoses/ conditions/risk factors and dates of occurrence)
     - ☐ High risk for a cardiovascular disease (CVD) event without established atherosclerotic CVD (ASCVD)
     - ☐ Established atherosclerotic CVD (ASCVD)

     Diagnosis/condition/risk factor: _____

     Date of occurrence:_____

     Diagnosis/condition/risk factor: _____

     Date of occurrence:_____
2. Will Nexletol® or Nexlizet® be used as an adjunct to diet and other low-density lipoprotein cholesterol (LDL-C) lowering therapies to reduce LDL-C? Yes☐ No☐

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.	

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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: _____

_____

_____

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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