

PRIOR AUTHORIZATION REQUEST FORM
NEXLETOL[®], NEXLIZET[™]

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: Nexletol[®] (bempedoic acid), Nexlizet[™] (bempedoic acid/ezetimibe)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Does the member have a documented diagnosis of heterozygous familial hypercholesterolemia or established atherosclerotic cardiovascular disease?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Has the member demonstrated at least 80% compliance with high intensity statin therapy or contraindication/intolerance to at least 4 generic statin therapies?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Is the member's fasting LDL-C level > 70mg/dL?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Is the member taking a proprotein convertase substilisin/kexin 9 inhibitor (PCSK9)?	<input type="checkbox"/>	<input type="checkbox"/>	

REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation show a decrease in baseline LDL-C level of at least 15% from baseline?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

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Additional information:

Physician Signature:

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy: PHARM- 099
Origination Date: 08/10/2020
Reviewed/Revised Date: 08/19/2020
Next Review Date: 08/19/2021
Current Effective Date: 09/01/2020

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