OKLAHOMA Health Care Authority

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State of Oklahoma
SoonerCare
Nexletol® (Bempedoic Acid) & 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:*** _____

Billing Provider Information

Pharmacy NPI: _____ ***Pharmacy Name:*** _____

Pharmacy Phone: _____ ***Pharmacy Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

All information must be provided and SoonerCare may verify through further requested documentation. The member's prescription claims history will be reviewed prior to approval.

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 (*genetic testing results must be submitted with the prior authorization request*)
     - ☐ 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
   - ☐ Established atherosclerotic cardiovascular disease (ASCVD). Please provide supporting diagnoses/conditions and dates of occurrence signifying established ASCVD:

   Diagnosis/condition: _____ Date of occurrence: _____
   Diagnosis/condition: _____ Date of occurrence: _____
2. How will this medication be used? ☐ Monotherapy ☐ Adjunct to statin therapy, diet, and exercise
3. Please specify the member's current statin therapy:
   a. Has the member been on a stable dose of maximally tolerated 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 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 maximally tolerated 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: _____

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.*

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.**	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*