OKLAHOMA
Health Care Authority

# 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.*

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