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 of the following:
     - ❑ Simon Broome Register criteria
     - ❑ Dutch Lipid Network criteria
     - ❑ Genetic testing
   - ❑ 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. Please specify the member's current statin therapy:

   Drug Name:_____ Dose:_____ Duration of treatment:_____
   a. Has the member been on a stable dose of maximally tolerated statin therapy for at least 4 weeks? Yes☐ No☐
   b. Has the member had statin trials prior to current statin therapy? Yes☐ No☐
      i. If yes, please list:

   Drug Name:_____ Dose:_____ Duration of treatment:_____
   c. Please provide member's LDL-C level(s) following 4 weeks of each statin therapy trial:_____ _____
   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☐
   f. If member has discontinued statin therapy, please provide the reason for discontinuation:

   _____
   g. If member is statin intolerant due to myalgia, provide creatine kinase (CK) labs verifying rhabdomyolysis.

   Members with myalgia not confirmed by CK labs must have at least 2 trials of lower dose statin therapy or failure of intermittent dosing.
3. Member's baseline LDL-C:_____ Current LDL-C:_____ Goal LDL-C:_____
4. How will this medication be used? □ Monotherapy □ Adjunct to statin therapy, diet, and exercise

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:	CONFIDENTIALITY NOTICE
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	*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.*

OHCA Approved – 03/08/2021