US Family Health Plan
Prior Authorization Request Form for
bempedoic acid **(Nexletol),** bempedoic acid/ezetimibe **(Nexlizet)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007** **usfamilyhealth.org/rx-pa**

Step 1 Please complete patient and physician information (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 Please complete the clinical assessment:

1. Is the requested medication prescribed by a cardiologist, endocrinologist or lipidologist (for example, the provider is certified through the National Lipid Association or similar organization)?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the patient at high risk for atherosclerotic cardiovascular disease (ASCVD) based on history of clinical (ASCVD), including one or more of the following: • **acute coronary syndrome (ACS),** • **coronary artery disease (CAD),** • **myocardial infarction (MI),** • **stable or unstable angina,** • **coronary or arterial revascularization,** • **stroke,** • **transient ischemic attack (TIA),** • **peripheral artery disease (PAD)?**	☐ Yes Proceed to question **4**	☐ No Proceed to question **3**
3. Is the patient at high risk for atherosclerotic cardiovascular disease (ASCVD) based on Heterozygous Familial Hypercholesterolemia (HeFH)?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the patient on concurrent statin therapy at the maximum tolerated dose and hasn't reached LDL goals?	☐ Yes Proceed to question **9**	☐ No Proceed to question **5**
5. Has the patient experienced intolerable and persistent (lasting longer than 2 weeks) muscle symptoms (muscle pain, cramp) with at least 2 statins?	☐ Yes Proceed to question **9**	☐ No Proceed to question **6**

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6. Does the patient have a history of creatine kinase (CK) levels greater than 10 x the upper limit of normal (ULN) unrelated to statin use?	☐ Yes Proceed to question **9**	☐ No Proceed to question **7**
7. Does the patient have a history of statin-associated rhabdomyolysis?	☐ Yes Proceed to question **9**	☐ No Proceed to question **8**
8. Does the patient have a contraindication to statin therapy (for example, active liver disease, including unexplained or persistent elevations in hepatic transaminase levels, hypersensitivity, pregnancy)?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. What is the requested medication?	☐ Nexletol - Proceed to question **10** ☐ Nexlizet - Proceed to question **12**	
10. Is the patient taking ezetimibe concurrently?	☐ Yes **Sign and date below**	☐ No Proceed to question **11**
11. Has the patient tried and was able to tolerate an ezetimibe trial of at least 4-6 weeks?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
12. Is the patient currently taking ezetimibe?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Will ezetimibe be discontinued once Nexlizet is started?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[11 November 2020]