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: ACS, CAD, MI, stable or unstable angina, coronary or arterial revascularization, stroke, TIA, 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**
6. Does the patient have a history of creatine kinase (CK) levels greater than 10 x the 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**

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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. Was the patient 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 taking ezetimibe concurrently, which will 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 _____