

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**

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)?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> 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: <ul style="list-style-type: none"> • 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)? 	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No Proceed to question 3
3. Is the patient at high risk for atherosclerotic cardiovascular disease (ASCVD) based on Heterozygous Familial Hypercholesterolemia (HeFH)?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. Is the patient on concurrent statin therapy at the maximum tolerated dose and hasn't reached LDL goals?	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No Proceed to question 7
7. Does the patient have a history of statin-associated rhabdomyolysis?	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> 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)?	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No STOP Coverage not approved
9. What is the requested medication?	<input type="checkbox"/> Nexletol - Proceed to question 10 <input type="checkbox"/> Nexlizet - Proceed to question 12	
10. Is the patient taking ezetimibe concurrently?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 11
11. Has the patient tried and failed to tolerate an ezetimibe trial of at least 4-6 weeks?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
12. Is the patient currently taking ezetimibe?	<input type="checkbox"/> Yes Proceed to question 13	<input type="checkbox"/> No STOP Coverage not approved
13. Will ezetimibe be discontinued once Nexlizet is started?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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