Trillium Health Resources
Pharmacy Prior Approval Request for

Nexletol and Nexlizet

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
3. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: _____ 2. Strength: _____ 3. Quantity Per 30 Days: _____
4. Length of Therapy (in Days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

Initial Coverage Nexletol questions 1-5) and Nexlizet (questions 1-7)

1. Is the member at least 18 years old or older? ☐ **Yes** ☐ **No**
2. Has the member been diagnosed with heterozygous familial hypercholesterolemia (HeFH) or established atherosclerotic cardiovascular disease (ASCVD) defined as acute coronary syndromes, or a history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack, or peripheral arterial disease of atherosclerotic origin? ☐ **Yes** ☐ **No**
3. Has the member failed to achieve a target LDL-C (at least 50% reduction from baseline OR if no baseline is available: <70mg/dL for members with ASCVD and <100mg/dL for members with HeFH, and no history of ASCVD) despite physician attestation that the member is adherent to maximally-tolerated doses of statins for at least 90 days duration prior to the lipid panel demonstrating suboptimal reduction? ☐ **Yes** ☐ **No**
4. Is therapy being used in conjunction with maximally-tolerated doses of a statin? ☐ **Yes** ☐ **No**
5. Will therapy NOT be used with concurrent doses of simvastatin > 20gm or pravastatin > 40mg? ☐ **Yes** ☐ **No**

Initial Coverage Nexlizet (questions 6-7)

6. For Nexlizet- Does the beneficiary have a hypersensitivity to ezetimibe (Zetia®)? ☐ **Yes** ☐ **No**
7. Will Nexlizet be used with concurrent fibrate therapy (excluding fenofibrate)? ☐ **Yes** ☐ **No**

Continuation of Coverage for Nexletol and Nexlizet

8. Does the member continue to meet initial criteria above? ☐ **Yes** ☐ **No**
9. Is the member absent of unacceptable toxicity from therapy. (Examples of unacceptable toxicity include the following: hyperuricemia, tendon rupture)? ☐ **Yes** ☐ **No**
10. Does laboratory analysis demonstrate a reduction in LDL-C when compared to the baseline values (prior to initiating bempedoic acid or bempedoic acid/ezetimibe)? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277