Montana Healthcare Programs Prior Authorization Request Form for Use of Nexletol (bempedoic acid)

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>DOB:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Member ID:</td>
<td>Prescriber Phone:</td>
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<tr>
<td>Prescriber Name/Specialty:</td>
<td>Prescriber Fax:</td>
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<td>Requested Drug/Dose/Directions:</td>
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Please complete below information for applicable situation, **Initiation** or **Continuation** of therapy:

☐ **INITIATION OF THERAPY** (member must meet **all the following criteria**):

1. Member is 18 years of age or older: ☐ Yes ☐ No
2. Medication is prescribed by or in consult with a cardiologist, endocrinologist or lipidologist: ☐ Yes ☐ No
   **Action Required**: If not in a speciality clinic or written by a specialist, information on annual consult with an appropriate specialist is required:
   Name: __________________________ Contact date: __________________________
3. Member has an LDL-cholesterol equal to or greater than 70mg/dl: ☐ Yes ☐ No
   Please provide LDL baseline: __________________________ Date: __________________________
4. Member has a diagnosis of either:
   ☐ Heterozygous Familial Hypercholesterolemia (HeFH)
   ☐ Atherosclerotic Cardiovascular Disease (ASCVD)
5. Member must have trialed at least **two** high intensity statins (i.e. atorvastatin/rosuvastatin) for at least 12 weeks:
   **First statin used/dose**: __________________________ Statin dates: __________________________
   Reason for discontinuation: __________________________
   **Second statin used/dose**: __________________________ Statin dates: __________________________
   Reason for discontinuation: __________________________
6. Member will continue receiving a maximally tolerated high intensity statin: ☐ Yes ☐ No
   Drug name: __________________________
   If no, please indicate the reason: __________________________
7. Member has trialed ezetimibe for at least 12 weeks: ☐ Yes ☐ No
   Dates of use: __________________________ Reason for discontinuation: __________________________
8. Member has trialed a PCSK-9 Inhibitor (Praluent/Repatha) for at least 12 weeks and has been ineffective or contraindicated: □ Yes □ No

   Dates of use: ___________________ Reason for discontinuation: ______________________________

LIMITATIONS: Maximum daily dose is 180mg/day

   Initial authorization will be granted for 6 months.

☐ CONTINUATION OF THERAPY:

1. Member has been adherent to Nexletol: □ Yes □ No
2. Member has been adherent to statin at maximally tolerated dose: □ Yes □ No
3. Member has experienced a positive clinical response (i.e., reduction in LDL): □ Yes □ No

   Action required: Please attach lab work.

4. Annual specialist consult attached if prescriber is not a specialist: □ Yes □ No □ N/A – prescriber is specialist.

   Reauthorization will be issued for 1 year.

Please complete form, including required attachments and fax to Drug Prior Authorization Unit at 1-800-294-1350.

05/2022