

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

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty:	Prescriber Fax:	
Requested Drug/Dose/Directions:		

*Please complete below information for applicable situation, **Initiation** or **Continuation** of therapy:*

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

- Member is 18 years of age or older: ☐ Yes ☐ No
- 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: _____

- Member has an LDL-cholesterol equal to or greater than 70mg/dl: ☐ Yes ☐ No

Please provide LDL baseline: _____ Date: _____

- Member has a diagnosis of either:

- ☐ Heterozygous Familial Hypercholesterolemia (HeFH)
- ☐ Atherosclerotic Cardiovascular Disease (ASCVD)

- 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: _____

- Member will continue receiving a maximally tolerated high intensity statin: ☐ Yes ☐ No

Drug name: _____

If no, please indicate the reason: _____

- 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.**