Montana Healthcare Programs Prior Authorization Request Form for Use of Nexlizet (bempedoic acid and ezetimibe)

<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>
<td></td>
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<tr>
<td>Prescriber Name/Specialty:</td>
<td>Prescriber Fax:</td>
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<tr>
<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 of 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: __________________________

*Note: The initial 12-week trial of ezetimibe must be trialed on its own prior to considering approval for the combination bempedoic acid/ezetimide product.*
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 Nexlizet: ☐ 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 a 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