Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health
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Montana Healthcare Programs Prior Authorization Request Form for Use of Nexlizet (bempedoic acid and ezetimibe)

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 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 <u>*two*</u> 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 tolereated 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