AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: (select drug below)

❑ **Nexletol**™ (bempedoic acid)	❑ **Nexlizet**™ (bempedoic acid/ezetimibe)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization Approval: 6 months

- ❑ Must be prescribed or in consultation with one of the following:
  - ❑ Cardiologist
  - ❑ Endocrinologist
  - ❑ Lipid Specialist

(Continued on next page)

DIAGNOSIS: select one below:

- ❑ Atherosclerotic Cardiovascular Disease
- ❑ Heterozygous Familial Hypercholesterolemia (HeFH)
- ❑ Other diagnosis: _____
- ❑ ICD-10 Code(s) plus description: _____

❑ **Atherosclerotic Cardiovascular Disease** – Select if the member has Atherosclerotic cardiovascular disease (ASCVD) confirmed by the following: **(Please note: Chart documentation is required to be submitted along with this request form.)**

- ❑ Acute coronary syndrome
- ❑ History of myocardial infarction
- ❑ Stable or unstable angina
- ❑ Coronary or other arterial revascularization (e.g., percutaneous coronary intervention (PCI), angioplasty, coronary stent procedure or coronary bypass graft (CABG) surgery)
- ❑ Stroke
- ❑ Transient ischemic attack
- ❑ Peripheral arterial disease presumed to be of atherosclerotic origin

OR

❑ **Heterozygous Familial Hypercholesterolemia (HeFH) –** Select if the member has Heterozygous familial hypercholesterolemia (HeFH) confirmed by the following: **(Please note: Chart documentation is required to be submitted along with this request form.)**

- ❑ Untreated/pre-treatment LDL cholesterol (LDL-C) ≥ 190mg/dL in an adult or ≥ 155mg/dL in a child less than 16 years of age

AND (ONE OF THE FOLLOWING)

- ❑ Family history of myocardial infarction in first-degree relative less than 60 years of age
- ❑ Family history of myocardial infarction in second-degree relative less than 50 years of age
- ❑ Family history of familial hypercholesterolemia in first-or second degree relative
- ❑ Submission of medical records (e.g., chart notes, laboratory values) documenting LDL-C > 190mg/dL in first or second degree relative.ransient ischemic attack

OR (ONE OF THE FOLLOWING)

- ❑ Genetic confirmation of functional mutation in the LDL receptor, Apo-B, or PCSK9 gene adaptor protein 1 (i.e., LDLRAP1 or ARH)
- ❑ Tendinous xanthomata
- ❑ Arcus cornealius before age 45

AND

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❑ **Please confirm ALL of the following for ASCVD and/or HeFH:** (Please note: Chart documentation is required to be submitted along with this request form.)

❑ Member is on high-intensity statin therapy (i.e., atorvastatin 40-80mg daily, rosuvastatin 20-40mg daily) **AND** ezetimibe concomitantly (unless the addition of ezetimibe is contraindicated) for > 12 continuous weeks **(Pharmacy claims will be verified)**

OR

❑ Member is unable to tolerate high intensity statin therapy and is on maximally tolerated statin therapy **AND** ezetimibe concomitantly (unless the addition of ezetimibe is contraindicated) for > 12 continuous weeks **(Pharmacy claims will be verified)**

Statin: _____ **Strength:** _____ **Date started:** _____

AND (ONE OF THE FOLLOWING)

❑ LDL-C remains greater than or equal to 70 mg/dL with ASCVD

❑ LDL-C remains greater than or equal to 100 mg/dL without ASCVD

****Please document: the LDL levels below (Labs MUST be attached or authorization will be delayed)****

LDL baseline: _____ **LDL post therapy:** _____

OR

❑ Member is unable to tolerate statin therapy as evidenced by **ONE** of the following intolerable and persistent symptoms with **TWO** different statins (i.e., trial of at least 14 days of each) **(documentation MUST be provided and claims will be verified)**:

- ❑ Myalgia (muscle symptoms without CK elevations) **OR**
- ❑ Myositis (muscle symptoms with CK elevations < 10 times upper limit of normal)

AND

❑ Reinitiating of statin therapy at lower dose or reduced frequency of administration must have been attempted and failed **(documentation of statin intolerance MUST be provided)**

****Please document statin therapy below; pharmacy claims will be verified****

Statin: _____ Strength: _____ Date started: _____

Statin: _____ Strength: _____ Date started: _____

OR

❑ Member has a labeled contraindication to ALL statins as documented in medical records and/or has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations > 10 times upper limit of normal **(documentation of labeled contraindication to ALL statins must be provided)**

AND

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- ❑ Member has had a **90-Day** trial of a PCSK9 inhibitor (i.e., Repatha® or Praluent® - require prior authorization) and failed to reach LDL target goal **(documentation of PCSK9 inhibitor failure, including LDL labs after 90 days of therapy, MUST be provided)**

OR

- ❑ Member has had a life-threatening adverse reaction to a PCSK9 inhibitors (i.e., Repatha® or Praluent® – required prior authorization) **(documentation of life-threatening adverse reaction MUST be provided)**

****Please note: Concomitant therapy with PCSK9 inhibitors will not be approved****

Reauthorization Approval: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Documentation of positive clinical response to therapy (e.g., reduction in LDL-C levels)

AND

- ❑ Patient continues to receive other lipid-lowering therapy (e.g., statin, ezetimibe) at a maximally tolerated dose

OR

- ❑ Patient has a documented inability to take other lipid-lowering therapy (e.g., statins, ezetimibe)

****Please document: the LDL levels below (Labs MUST be attached or authorization will be delayed)****

LDL baseline: _____ LDL post-nexletol/nexlizet: _____

Medication being provided by a Specialty Pharmacy - PropriumRx

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pha rmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee:** 6/18/2020
REVISED/UPDATED/REFORMATTED: ~~8/31/2020;~~ **10/27/2023**