

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)

<input type="checkbox"/> Nexletol™ (bempedoic acid)	<input type="checkbox"/> Nexlizet™ (bempedoic acid/ezetimibe)
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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: 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 artery disease
- 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) \geq 190mg/dL in an adult or \geq 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

OR (ONE OF THE FOLLOWING)

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- 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

Please confirm ALL 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

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- ❑ 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

- ❑ 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**)

Reauthorization: 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

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

OR

- ❑ Member 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 – Proprium Rx

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 pharmacy paid claims or submitted chart notes.****