UnitedHealthcare Community Plan

NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Nexletol and Nexlizet

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. ____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

Criteria for Initial Coverage of Nexletol (questions 1-5) and Nexlizet (questions 1-7)

1. Is the recipient at least 18 years old or older? ☐ **Yes** ☐ **No**
2. Has the beneficiary been diagnosed with heterozygous familial hypercholesterolemia (HeFH) or established atherosclerotic cardiovascular disease (ASCVD) defined as acute coronary syndromes, or a history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack, or peripheral arterial disease of atherosclerotic origin?.☐ **Yes** ☐ **No**
3. Has the beneficiary failed to achieve a target LDL-C (at least 50% reduction from baseline OR if no baseline is available: <70 mg/dL for beneficiaries with ASCVD and <100 mg /dL for beneficiaries with HeFH, and no history of ASCVD) despite physician attestation that the beneficiary is adherent to maximally-tolerated doses of statins for at least 90 days duration prior to the lipid panel demonstrating suboptimal reduction? ☐ **Yes** ☐ **No**
4. Is therapy being used in conjunction with maximally-tolerated doses of a statin? ☐ **Yes** ☐ **No**
5. Will therapy **NOT** be used with concurrent doses of simvastatin > 20gm or pravastatin > 40mg? ☐ **Yes** ☐ **No**

For Nexlizet answer 1-5 above and 6-7 below.

6. For **NEXLIZET**- Does the beneficiary have a hypersensitivity to ezetimibe (Zetia®)? ☐ **Yes** ☐ **No**
7. Will **NEXLIZET** be used with concurrent fibrate therapy (excluding fenofibrate)? ☐ **Yes** ☐ **No**

Continuation of Coverage for Nexletol and Nexlizet

8. Does the beneficiary continue to meet initial criteria above? ☐ **Yes** ☐ **No**
9. Is the beneficiary absent of unacceptable toxicity from therapy. (Examples of unacceptable toxicity include the following: hyperuricemia, tendon rupture)? ☐ **Yes** ☐ **No**
10. Does laboratory analysis demonstrate a reduction in LDL-C when compared to the baseline values (prior to initiating bempedoic acid or bempedoic acid/ezetimibe)? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____
(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to 1-866-940-7328 Pharmacy PA Call Center: 1-855-258-1593