Nexletol (bempedoic acid)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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Revision Date: 3/15/24

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Atherosclerotic Cardiovascular Disease (ASCVD) □ Heterozygous Familial Hypercholesterolemia (HeFH) □ Other diagnosis: _____ICD-10:_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Does the patient have any of the following: □ **Yes** □ **No** ***Please submit documentation***

- History of myocardial infarction more than 3 months ago
- History of coronary revascularization procedure more than 3 months ago
- Greater than 50% stenosis of at least one major coronary artery, as documented in an imaging report
- Claudication or resting limb ischemia with ankle brachial index of 0.9 or lower, as documented by an imaging report showing at least 50% stenosis
- Peripheral artery revascularization more than 3 months ago
- Confirmed abdominal aortic aneurysm
- History of lower extremity amputation
- Ischemic stroke more than 3 months ago
- History of carotid endarterectomy, carotid stenting or more than 70% stenosis in a carotid artery as documented in an imaging report

Does the patient have any of the following: □ **Yes** □ **No** ***Please submit documentation***

- Genetic confirmation of a mutation in the low-density lipoprotein (LDL) receptor, ApoB,or PCSK9 in patient with untreated/ pre-treatment LDL-C greater than 190 mg/dL
- Presence of tendinous xanthomas in: (1.) patient, first degree relative, or second degree relative with untreated/pre-treatment LDL-cholesterol (LDL-C) >190 mg/dL (age 18 years and older) OR (2) in a first- or second-degree relative with untreated/pre-treatment LDL-C >155mg/dL (age less than 18 years)
- Documented assessment of patient using Dutch Lipid Clinic Network diagnostic criteria with a cumulative score greater than or equal to 9 points (i.e., definite FH) –(calculation with final score must be submitted);

Is the patient currently on a statin? □ **Yes** □ **No**

If the patient is not able to use a maximum dose of a statin due to muscle symptoms, a causal relationship must be established between statin use and muscle symptoms such as:

Does the patient have evidence of pain, tenderness, stiffness, cramping, weakness, and/or fatigue and all of the following? □ **Yes** □ **No** ***Please provide documentation.***

Does patient have muscle symptoms that resolve after discontinuation of statin? □ **Yes** □ **No** ***Please provide documentation.***

Does patient have muscle symptoms occurring when re-challenged at a lower dose of the same statin? □ **Yes** □ **No** ***Please provide documentation.***

Did muscle symptoms occurr after switching to an alternative statin? □ **Yes** □ **No** ***Please provide documentation.***

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Has non-statin causes of muscle symptoms (e.g., hypothyroidism, reduced renal function, reduced hepatic function, rheumatologic disorders, such as polymyalgia rheumatica, steroid myopathy, vitamin D deficiency, or primary muscle disease) have been ruled out? □ Yes □ No *Please provide documentation.*

Has The patient been diagnosed with rhabdomyolysis associated with statin use? □ Yes □ No *Please provide documentation.*

Did the patient experience acute neuromuscular illness or dark urine and an acute elevation in creatine kinase? □ Yes □ No *Please provide documentation.*

Has the patient had a previous trial with ezetimibe(Zetia)?* Yes □ No *Please provide documentation.

Does the patient have an absolute contraindication to ezetimibe(Zetia)?* Yes □ No *Please provide documentation.

Does the patient have a fasting LDL-C level greater than or equal to 70 mg/dL? □ Yes □ No
Please submit documentation

Does the patient have fasting triglycerides less than 500 mg/dL? □ Yes □ No *Please submit documentation*

Does the patient have a BMI less than 50 kg/m^2? □ Yes □ No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review? □ Yes □ No

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***Please note:** Not all drugs/diagnoses are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Revision Date: 3/15/24

Prime THERAPEUTICS™