SENTARA COMMUNITY PLAN
(MEDICAID)

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 1-800-750-9692**. 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)

Preferred Medication (must be tried and failed FIRST)
❑ **ezetimibe**

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

Member Name: _____

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

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

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

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

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

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

Weight (if applicable): _____ **Date weight obtained:** _____

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.

Specialty: Is the drug prescribed by or in consultation with a specialist?

❑ Cardiologists	❑ Lipidologists
❑ Endocrinologists	❑ Other: _____

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1. Is Patient ≥ 18 years of age? ❑ Yes ❑ No
2. For what indications the drug is being prescribed? Check all that apply:
   - ❑ Member can be classified into ONE of the following risk factor groups:
     - ❑ Extremely high risk ASCVD: (defined as extensive or active burden of ASCVD, or ASCVD with extremely high burden of adverse or poorly controlled risk cardio-metabolic risk factors including HeFH or severe hypercholesterolemia [SH] LDL-C > 220 mg/dl) with an LDL-C ≥ 70 mg/dL; **OR**
     - ❑ Very high risk ASCVD: (defined as less extensive ASCVD and poorly controlled cardiometabolic risk factors) with an LDL-C ≥ 100 mg/dL; **OR**
     - ❑ High risk ASCVD: (defined as either less extensive ASCVD and well controlled risk factors or primary prevention HeFH or SH >220 mg/dl with poorly controlled risk factors) with LDL-C ≥ 130 mg/dL;
   - ❑ To reduce the risk of myocardial infarction, stroke, and coronary revascularization in adults without established cardiovascular disease.
   - ❑ As an adjunct to diet, alone or in combination with other lipid-lowering therapies (e.g., statins, ezetimibe), for treatment of adults with primary hyperlipidemia (including heterozygous familial hypercholesterolemia (HeFH)) to reduce low-density lipoprotein cholesterol (LDL-C)
3. Member has failed to achieve a target LDL-C despite physician attestation that the member is adherent to maximally tolerated doses of statins prior to the lipid panel demonstrating suboptimal reduction
   ❑ Yes ❑ No
4. Member is not able to use a maximum dose of atorvastatin or rosuvastatin due to muscle symptoms? Documentation of a causal relationship must be established between statin use and muscle symptoms. Documentation must demonstrate that the member experienced pain, tenderness, stiffness, cramping, weakness, and/or fatigue and all of the following **(please attach documentation)**:
   a. Muscle symptoms resolved after discontinuation of statin;

      AND

   b. Muscle symptoms occurred when re-challenged at a lower dose of the same statin;

      AND

   c. Muscle symptoms occurred after switching to an alternative statin;

      AND

   d. Documentation ruling out 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);

      OR

   e. Member has been diagnosed with statin-induced rhabdomyolysis

   ❑ Yes ❑ No
5. Is this request for a new start or continuation of therapy? (If **New Start**, go to diagnosis section.)
   ❑ New Start ❑ Continuation

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❑ High risk for Cardiovascular Disease (CVD) event but WITHOUT established CVD

6. Member is at high risk for a CVD event but without established CVD confirmed by at least **ONE** of the following **(submit documentation)**:
   - ❑ Reynolds risk score > 30 %
   - ❑ 10-year ASCVD risk score ≥ 20 %
   - ❑ Coronary artery calcium score > 300 Agatston units
   - ❑ Member is between 40 and 75 years of age and has a diagnosis of Type 1 or 2 diabetes
7. Member must meet **ONE** of the following:
   - ❑ Member has tried **ONE** of the following statin therapies as a single-entity or combination product for at least 8 consecutive weeks **(verified by pharmacy paid claims)**:
     - ❑ High intensity statin therapy with atorvastatin (generic Lipitor) ≥ 40 mg daily
     - ❑ High intensity statin therapy rosuvastatin (generic Crestor) ≥ 20 mg daily
     - ❑ Moderate-intensity statin therapy (member unable to tolerate high intensity therapy)
     - ❑ Low intensity statin therapy (member unable to tolerate moderate intensity therapy **OR**
   - ❑ Member has been determined to be statin intolerant and meets all clinical criteria in question #4.
8. If applicable: Member's LDL-C after 8-week trial of maximally tolerated statin therapy remains ≥ 70 mg/dL ❑ Yes ❑ No
9. Please provide member's LDL levels below (submit labs with request):

   LDL baseline: _____

❑ Diagnosis and Lab Values for Cardiovascular Event Risk Reduction (CVD)

10. Does member have a history of clinical atherosclerotic cardiovascular disease (ASCVD) or a cardiovascular event listed below? ❑ Yes ❑ No
    - ❑ Acute coronary syndromes
    - ❑ Myocardial infarction
    - ❑ Stable or unstable angina
    - ❑ Stroke of presumed atherosclerotic origin
    - ❑ Transient ischemic attack (TIA)
    - ❑ Coronary or other arterial revascularization procedure (e.g., percutaneous transluminal coronary angioplasty (PTCA), coronary artery bypass graft (CABG))
    - ❑ Peripheral arterial disease of presumed atherosclerotic origin
    - ❑ Findings from computerized tomography (CT) angiogram or catheterization consistent with clinical ASCVD
11. Please provide member's LDL levels below **(submit labs with request)**:

    LDL baseline: _____

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❑ Diagnosis and Lab Values for Heterozygous Familial Hypercholesterolemia (HEFH)

12. Does member have a **definite** diagnosis of heterozygous familial hypercholesterolemia (HeFH) as defined by the Dutch Lipid Clinical Network criteria (total score greater than 8)?

    ACTION REQUIRED: If **YES**, please provide a copy of the lab report with LDL-C level at time of diagnosis and other documentation supporting clinical/family history and/or physical findings (e.g., chart notes, medical records).

    ❑ Yes ❑ No

13. Does member have a definite diagnosis of HeFH as defined by Simon Broome diagnostic criteria?

    ❑ Yes ❑ No

Reauthorization Approval

14. Was this drug previously authorized for this member and are they stable on the medication?

    ❑ Yes ❑ No

15. How long has the member been receiving treatment with these medications?
    - ❑ 3 to 5 months (or first renewal request after initial authorization)
    - ❑ 6 months or more (or second and subsequent renewal requests)

16. Has the member achieved at least a 15% to 20% reduction in LDL-C since the beginning of treatment? (If Yes, please attach clinical notes and laboratory results that support reduction in LDL-C after initiation of therapy.)

    ❑ Yes ❑ No

17. Does the member continue to benefit from treatment as measured by either continued decrease in LDL-C levels or maintenance of optimum of LDL-C levels? (If Yes, please attach clinical notes and laboratory results that support continued benefit of Nexletol®, Nexlizet™ therapy.)

    ❑ Yes ❑ No

18. Member is not able to use a maximum dose of atorvastatin or rosuvastatin due to muscle symptoms; documentation of a causal relationship must be established between statin use and muscle symptoms. Documentation must demonstrate that the member experienced pain, tenderness, stiffness, cramping, weakness, and/or fatigue. (Please provide documentation/chart notes)

    ❑ Yes ❑ No

Medication being provided by Specialty Pharmacy - PropriumRx

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.