Prior Authorization Form

CAREFIRST

Nexletol- Nexlizet PA with Logic

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Nexletol- Nexlizet PA with Logic.

Drug Name (select from list of drugs shown)

Nexletol (bempedoic acid) Nexlizet (bempedoic acid-ezetimibe)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1.	Is the requested drug being prescribed to reduce low-density lipoprotein cholesterol (LDL-C) in an adult with primary hyperlipidemia, including heterozygous familial hypercholesterolemia (HeFH)?	Y N
	[If Yes, then go to 2. If No, then go to 7.]	
2.	Is the requested drug being prescribed as an adjunct to diet?	Y N
	[If Yes, then go to 3. If No, then no further questions.]	
3.	Is this request for continuation of therapy?	Y N
	[If Yes, then go to 4. If No, then go to 5.]	

4.	Has the patient achieved or maintained a reduction in low-density lipoprotein cholesterol (LDL-C) from baseline?	Y N
	[No further questions.]	
5.	Will the requested drug be used in combination with other low-density lipoprotein cholesterol (LDL-C) lowering therapies?	Y N
	[If Yes, then no further questions. If No, then go to 6.]	
6.	Is concomitant use of the requested drug with other low-density lipoprotein cholesterol (LDL-C) lowering therapies not possible?	Y N
	[No further questions.]	
7.	Is the requested drug being used to reduce the risk of myocardial infarction and coronary revascularization in an adult?	Y N
	[If Yes, then go to 8. If No, then no further questions.]	
8.	Does the patient have ANY of the following: A) established cardiovascular disease (CVD), B) a high risk for a cardiovascular disease (CVD) event but without established CVD?	Y N
	[If Yes, then go to 9. If No, then no further questions.]	
9.	Has the patient experienced an intolerance to the recommended statin therapy?	Y N
	[If Yes, then no further questions. If No, then go to 10.]	
10.	Does the patient have a contraindication that would prohibit use of statin therapy?	Y N
	[No further questions.]	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date