BlueCross BlueShield Federal Employee Program

NEXLETOL / NEXLIZET PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

NOTE: Form must be completed in its **entirety** for processing

Please select medication: ❑**Nexletol (bempedoic acid)** ❑**Nexlizet (bempedoic acid/ezetimibe)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Has the patient been on this medication continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 3**
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Will the patient need more than 90 tablets every 90 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ tablets every 90 days
4. What is the patient's diagnosis?

   ❑Atherosclerotic Cardiovascular Disease (ASCVD) **OR** ❑Hypercholesterolemia **OR** ❑Hyperlipidemia

   a. Has the patient been assessed for high risk of ASCVD or cardiovascular event based on a 10-year risk score by either the ASCVD Pooled Cohort Risk Assessment or the Predicting risk of cardiovascular disease EVENTs (PREVENT) Score? ❑Yes* ❑No

      If YES, please select one of the following and provide the score:

      ❑ASCVD Pooled Cohort Risk Assessment Score: _____%

      ❑ Predicting risk of cardiovascular disease EVENTs (PREVENT) Score: _____%

   b. Does the patient have a documented history of **ONE** of the following ASVD or cardiovascular events below:

      ❑**None of the events listed**
      ❑Acute coronary syndrome (ACS)
      ❑Myocardial infarction (MI)
      ❑Stable or unstable angina
      ❑Coronary or other arterial revascularization procedure (such as PTCA or CABG)
      ❑Findings from CT angiogram or catheterization consistent with clinical ASCVD
      ❑Peripheral arterial disease (PAD) presumed to be of atherosclerotic origin
      ❑Transient ischemic attack (TIA)

   c. Does the patient have an LDL-C level greater than or equal to 70 mg/dL in the past six months? ❑Yes ❑No

   ❑Heterozygous Familial Hypercholesterolemia (HeFH)

   a. Does the patient have a confirmed diagnosis by LDL-R DNA Sequencing Test or APOB (hypercholesterolemia) Mutation Analysis? ❑Yes* ❑No

      If YES, please select one of the following: ❑LDL-R DNA Sequence Test **OR** ❑APOB Mutation Analysis

   b. Does the patient have a Dutch Lipid Clinic Network Criteria Score greater than 5? ❑Yes ❑No ❑Not confirmed by this test

   c. Does the patient have a confirmed diagnosis per Simon-Broome Diagnostic Criteria for definite familial hypercholesterolemia? ❑Yes ❑No

   d. Does the patient have an LDL-C level greater than or equal to 100 mg/dL in the past six months? ❑Yes ❑No

   ❑Other diagnosis ***(please specify)***: _____
5. Will the patient be assessed for response, such as LDL-C reduction, and adherence to the prescribed lipid lowering regimen? ❑Yes ❑No
6. Does the patient have an intolerance or contraindication to statin therapy? ❑Yes ❑No*
   If NO, has the patient had an inadequate treatment response to statin therapy? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

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PAGE 2 – PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

7. Does the patient have an intolerance to higher dose or higher intensity statin therapy? ❑Yes ❑No

8. Will this medication be used in combination with maximally tolerated statin therapy? ❑Yes ❑No

9. Does the prescriber agree to monitor uric acid levels for hyperuricemia? ❑Yes ❑No

10. Will this medication be used in combination with another *****Prior Authorization (PA) lipid lowering agent? ❑Yes***** ❑No

If YES, please specify the medication: _____

****PA Lipid Lowering Agents: Juxtapid (lomitapide), Leqvio (inclisiran), Nexletol (bempedoic acid), Nexlizet (bempedoic acid/ezetimibe), Praluent (alirocumab), Repatha (evolocumab)***

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Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

CONTINUATION OF THERAPY (PA RENEWAL)

NOTE: Form must be completed in its **entirety** for processing

Please select medication: ❑**Nexletol (bempedoic acid)** ❑**Nexlizet (bempedoic acid/ezetimibe)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Has the patient been on this medication continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:

2. Is this request for brand or generic? ❑Brand ❑Generic

3. Will the patient need more than 90 tablets every 90 days? ❑Yes***** ❑No
   ***If YES**, please specify the requested quantity: _____ tablets every 90 days

4. What is the patient's diagnosis?
   ❑Atherosclerotic Cardiovascular Disease (ASCVD)
   ❑Heterozygous Familial Hypercholesterolemia (HeFH)
   ❑Hypercholesterolemia
   ❑Hyperlipidemia
   ❑Other diagnosis ***(please specify)***: _____

5. Will the patient be assessed for adherence to the prescribed lipid lowering regimen? ❑Yes ❑No

6. Is there a percentage reduction of LDL-C level greater than or equal to 20%, compared to the level immediately prior to starting therapy with this medication? ❑Yes ❑No*****
   ***If NO**, does the patient have an absolute LDL-C that is less than 100 mg/dL? ❑Yes ❑No

7. Does the prescriber agree to monitor uric acid levels for hyperuricemia? ❑Yes ❑No

8. Will this medication be used in combination with another *****Prior Authorization (PA) lipid lowering agent? ❑Yes***** ❑No
   ***If YES**, please specify the medication: _____
   ****PA Lipid Lowering Agents: Juxtapid (lomitapide), Leqvio (inclisiran), Nexletol (bempedoic acid), Nexlizet (bempedoic acid/ezetimibe), Praluent (alirocumab), Repatha (evolocumab)***