Prior Authorization Request Form for
bempedoic acid **(Nexletol),** bempedoic acid/ezetimibe **(Nexlizet)**

JOHNS HOPKINS MEDICINE

JOHNS HOPKINS HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 Please complete patient and physician information (please print):

Patient Name: ______________________ Physician Name: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Sponsor ID # ______________________ Phone #: ______________________

Date of Birth: Secure Fax #:

Step 2 Please complete the clinical assessment:

Question	Yes	No
1. Is the requested medication prescribed by a cardiologist, endocrinologist or lipidologist (for example, the provider is certified through the National Lipid Association or similar organization)?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the patient at high risk for atherosclerotic cardiovascular disease (ASCVD) based on history of clinical (ASCVD), including one or more of the following: • **acute coronary syndrome (ACS),** • **coronary artery disease (CAD),** • **myocardial infarction (MI),** • **stable or unstable angina,** • **coronary or arterial revascularization,** • **stroke,** • **transient ischemic attack (TIA),** • **peripheral artery disease (PAD)?**	☐ Yes Proceed to question **4**	☐ No Proceed to question **3**
3. Is the patient at high risk for atherosclerotic cardiovascular disease (ASCVD) based on Heterozygous Familial Hypercholesterolemia (HeFH)?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the patient on concurrent statin therapy at the maximum tolerated dose and hasn't reached LDL goals?	☐ Yes Proceed to question **9**	☐ No Proceed to question **5**
5. Has the patient experienced intolerable and persistent (lasting longer than 2 weeks) muscle symptoms (muscle pain, cramp) with at least 2 statins?	☐ Yes Proceed to question **9**	☐ No Proceed to question **6**

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Question	Yes	No
6. Does the patient have a history of creatine kinase (CK) levels greater than 10 x the upper limit of normal (ULN) unrelated to statin use?	☐ Yes Proceed to question **9**	☐ No Proceed to question **7**
7. Does the patient have a history of statin-associated rhabdomyolysis?	☐ Yes Proceed to question **9**	☐ No Proceed to question **8**
8. Does the patient have a contraindication to statin therapy (for example, active liver disease, including unexplained or persistent elevations in hepatic transaminase levels, hypersensitivity, pregnancy)?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. What is the requested medication?	☐ Nexletol - Proceed to question **10** ☐ Nexlizet - Proceed to question **12**	
10. Is the patient taking ezetimibe concurrently?	☐ Yes **Sign and date below**	☐ No Proceed to question **11**
11. Has the patient tried and was able to tolerate an ezetimibe trial of at least 4-6 weeks?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
12. Is the patient currently taking ezetimibe?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Will ezetimibe be discontinued once Nexlizet is started?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

______________________________ Prescriber Signature

__________ Date

[11 November 2020]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: