



**NC Medicaid  
Pharmacy Prior Approval Request for  
Nexletol and Nexlizet**

**Beneficiary Information**

1. Beneficiary Last Name: _____	2. First Name: _____
3. Beneficiary ID #: _____	4. Beneficiary Date of Birth: _____
5. Beneficiary Gender: _____	

**Prescriber Information**

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

**Drug Information**

8. Drug Name: _____	9. Strength: _____	10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): <input type="checkbox"/> up to 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> 120 Days <input type="checkbox"/> 180 Days <input type="checkbox"/> 365 Days		

**Clinical Information**

**Criteria for Initial Coverage of Nexletol (questions 1-5) and Nexlizet (questions 1-7)**

1. Is the recipient at least 18 years old or older?  Yes  No

2. Has the beneficiary been diagnosed with heterozygous familial hypercholesterolemia (HeFH) or established atherosclerotic cardiovascular disease (ASCVD) defined as acute coronary syndromes, or a history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack, or peripheral arterial disease of atherosclerotic origin?  Yes  No

3. Has the beneficiary failed to achieve a target LDL-C (at least 50% reduction from baseline OR if no baseline is available: <70 mg/dL for beneficiaries with ASCVD and <100 mg/dL for beneficiaries with HeFH, and no history of ASCVD) despite physician attestation that the beneficiary is adherent to maximally-tolerated doses of statins for at least 90 days duration prior to the lipid panel demonstrating suboptimal reduction?  Yes  No

4. Is therapy being used in conjunction with maximally-tolerated doses of a statin?  Yes  No

5. Will therapy **NOT** be used with concurrent doses of simvastatin > 20mg or pravastatin > 40mg?  Yes  No

**For Nexlizet answer 1-5 above and 6-7 below.**

6. For **NEXLIZET**- Does the beneficiary have a hypersensitivity to ezetimibe (Zetia®)?  Yes  No

7. Will **NEXLIZET** be used with concurrent fibrate therapy (excluding fenofibrate)?  Yes  No

**Continuation of Coverage for Nexletol and Nexlizet**

8. Does the beneficiary continue to meet initial criteria above?  Yes  No

9. Is the beneficiary absent of unacceptable toxicity from therapy. (Examples of unacceptable toxicity include the following: hyperuricemia, tendon rupture)?  Yes  No

10. Does laboratory analysis demonstrate a reduction in LDL-C when compared to the baseline values (prior to initiating bempedoic acid or bempedoic acid/ezetimibe)?  Yes  No

Signature of Prescriber: \_\_\_\_\_ Date: \_\_\_\_\_

**(Prescriber Signature Mandatory)**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to **1-800-678-3189**  
Pharmacy PA Call Center: **1-866-799-5318**