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Nexletol® & Nexlizet® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

This form may be faxed to 844-403-1029.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP:	Office Street Address:		
Phone:			City:	State:	ZIP:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
	Directions for Use:	

Clinical Information (required)

Atherosclerotic cardiovascular disease (ASCVD):	
1. Does the patient have ASCVD as confirmed by any of the following? *(If yes, check which applies)* □ Acute coronary syndromes □ Clinically significant coronary heart disease diagnosed by invasive or noninvasive testing (e.g., coronary angiography, stress test using treadmill, stress echocardiography or nuclear imaging) □ Coronary or other arterial revascularization (e.g., percutaneous coronary intervention [PCI] or coronary artery bypass graft [CABG] surgery) □ History of myocardial infarction □ Peripheral arterial disease presumed to be of atherosclerotic origin □ Stable or unstable angina □ Stroke □ Transient ischemic attack	❑ Yes ❑ No
Heterozygous familial hypercholesterolemia (HeFH):	
1. Does the patient have a diagnosis of heterozygous familial hypercholesterolemia (HeFH)?	❑ Yes ❑ No
2. Was the diagnosis of HeFH confirmed by an untreated/pre-treatment LDL-cholesterol (LDL-C) greater than 190 mg/dL (greater than 155 mg/dL if less than 16 years of age)?	❑ Yes ❑ No
3. Does the patient have any of the following? *(If yes, check which applies)* □ Family history of myocardial infarction in first-degree relative < 60 years of age □ Family history of myocardial infarction in second-degree relative < 50 years of age □ Family history of LDL-C greater than 190 mg/dL in first- or second-degree relative □ Family history of familial hypercholesterolemia in first- or second-degree relative □ Family history of tendinous xanthomata and/or arcus cornealis in first- or second degree relative	❑ Yes ❑ No
4. Does the patient have any of the following? *(If yes, check which applies)* □ Arcus cornealis before age 45 □ Functional mutation in LDL (low density lipoprotein), apoB (apolipoprotein B), or PCSK9 (proprotein convertase subtilisin/kexin type 9) gene □ Tendinous xanthomata	❑ Yes ❑ No

Nexletol® & Nexlizet® Prior Authorization Request Form (Page 2 of 2)

Atherosclerotic cardiovascular disease (ASCVD) AND Heterozygous familial hypercholesterolemia (HeFH):	
1. Has the patient been receiving at least 12 consecutive weeks of one HIGH-INTENSITY statin therapy [i.e., atorvastatin 40-80 mg, rosuvastatin 20-40 mg] and will continue to receive a HIGH-INTENSITY statin at maximally tolerated dose?	❑ Yes ❑ No
2. Is the patient is unable to tolerate high-intensity statin as evidenced by one of the following intolerable and persistent (i.e., more than 2 weeks) symptoms? *(If yes, check which applies)* □ Myalgia (muscle symptoms without creatine kinase [CK] elevations) □ Myositis (muscle symptoms with CK elevations < 10 times upper limit of normal [ULN])	❑ Yes ❑ No
3. Has the patient been receiving at least 12 consecutive weeks of one MODERATE-INTENSITY statin therapy [i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin 20-40 mg, pravastatin 40-80 mg, lovastatin 40 mg, Lescol XL (fluvastatin XL) 80 mg, fluvastatin 40 mg twice daily, or Livalo (pitavastatin) 2-4 mg] and will continue to receive a MODERATE-INTENSITY statin at maximally tolerated dose?	❑ Yes ❑ No
4. Has the patient been receiving at least 12 consecutive weeks of one LOW-INTENSITY statin therapy [i.e., simvastatin 10 mg, pravastatin 10-20 mg, lovastatin 20 mg, fluvastatin 20-40 mg, Livalo (pitavastatin) 1 mg] and will continue to receive a LOW-INTENSITY statin at maximally tolerated dose?	❑ Yes ❑ No
5. Is the patient is unable to tolerate low-, moderate, or high-intensity statins as evidenced by one of the following intolerable and persistent (i.e., more than 2 weeks) symptoms? *(If yes, check which applies)* □ Myalgia (muscle symptoms without creatine kinase [CK] elevations) □ Myositis (muscle symptoms with CK elevations < 10 times upper limit of normal [ULN])	❑ Yes ❑ No
6. Does the patient have a labeled contraindication to all statins?	❑ Yes ❑ No
7. Has the patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN?	❑ Yes ❑ No
8. Does the patient have one of the following LDL-C values while on maximally tolerated statin therapy within the last 120 days? (*(If yes, check which applies)* □ LDL-C greater than or equal to 70 mg/dL with ASCVD □ LDL-C greater than or equal to 100 mg/dL without ASCVD	❑ Yes ❑ No
9. Has the patient has been receiving at least 12 consecutive weeks of generic ezetimibe therapy as adjunct to maximally tolerated statin therapy?	❑ Yes ❑ No
10. Does the patient have a history of contraindication or intolerance to ezetimibe?	❑ Yes ❑ No
Reauthorization:	
1. Is there documentation of positive clinical response to therapy (e.g., reduction in LDL-C levels)?	❑ Yes ❑ No
2. Is the patient continuing to receive other lipid-lowering therapy (e.g., statins, ezetimibe) at the maximally tolerated dose?	❑ Yes ❑ No
3. Does the patient have a documented inability to take other lipid-lowering therapy (e.g., statins, ezetimibe)?	❑ Yes ❑ No

Information on this form is accurate as of this date.

Prescriber's Signature:	**Date:**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: **This request may be denied unless all required information is received.**
For more information about the prior authorization process, please contact us at 855-811-2218.
Monday – Friday: 8 a.m. to 1 a.m. Eastern, and Saturday: 9 a.m. to 6 p.m. Eastern.