Jefferson Health Plans

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Nexletol/Nexlizet - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Does the patient of a diagnosis of primary hyperlipidemia heterozygous familial hypercholesterolemia (HeFH) as defined by one of the following? Please attach documentation.
a. Genetic confirmation ; b. Dutch Lipid Network Criteria with a score greater than 6 points

☐ Yes ☐ No

Q2. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q3. Does the patient have primary hyperlipidemia with atherosclerotic cardiovascular disease (ASCVD)? Please attach documentation.

☐ Yes ☐ No

Q4. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q5. Has the patient had a prior treatment history with statin therapy?

☐ Yes ☐ No

Jefferson Health Plans

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Nexletol/Nexlizet - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

Q6. Has the patient experienced statin-associated side effects? Please attach documentation.

☐ Yes ☐ No

Q7. Does the patient have a condition that would be considered a contraindication to statin therapy, including active liver disease, or persistent elevation of serum transaminases?

☐ Yes ☐ No

Q8. Has the patient had a prior treatment history with ezetimibe therapy as adjunct to statin therapy or intolerance/contraindication to ezetimibe?

☐ Yes ☐ No

Q9. Have baseline labs (lipid profile) been attached?

☐ Yes ☐ No

Q10. Is this a request for a continuation of therapy?

☐ Yes ☐ No

Q11. Has an updated lipid profile been attached?

☐ Yes ☐ No

Q12. Additional Information:

Q13. Requested Duration:

☐ 12 months ☐ Other

_____ _____

Prescriber Signature Date