

MEDICARE ADVANTAGE 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.				
Member Name:		Prescriber Name:		
Member Number:		Fax:	Phone:	
Date of Birth:		Office Contact:		
Line of Business:	□ Medicare Advantage	NPI:	State Lic ID:	
Address:		Address:		
City, State ZIP:		City, State ZIP:		
Primary Phone:		Specialty/facility n	ame (if applicable):	
	DITED REVIEW: By checking this box and signing nrollee or the enrollee's ability to regain maximu		2 hour standard review timeframe may seriously jeopardize	
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. Is this a reauthorization request? If YES, go to 2. If NO, go to 3.				
☐ Yes		☐ No		
Q2. Has an updated lipid profile been attached?				
☐Yes		□ No		
Q3. Is there documentation showing that the medication is being used for an FDA-approved indication not otherwise excluded from Part D?				
☐ Yes		□ No		
Q4. Is the pat	tient 18 years of age or older?	,		
☐ Yes		□No		
Q5. Has the patient had a prior treatment history with statin therapy?				
□Yes		□No	□ No	
Q6. Has the բ	patient experienced statin-ass	ociated side effects?	Please attach documentation.	

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



MEDICARE ADVANTAGE 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.

Member Name:	Prescriber Name:		
□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 or intolerance/contraindication to ezetimibe?			
☐ Yes	□ No		
Q9. Have baseline labs (lipid profile) been attached?			
☐ Yes	□ No		
Q10. Requested Duration:			
☐ 12 Months	☐ Other:		
Q11. Additional Information:			
Prescriber Signature	Date		

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

v2025