REALRx

Healthy U
Health Choice Utah

PRIOR AUTHORIZATION REQUEST FORM
NEXLETOL®, NEXLIZET™

For authorization, please answer each question and fax this form PLUS chart notes back to the RealRx Medicaid Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for Pharmacy Customer Service for assistance.

- Healthy U Medicaid: 855-856-5694
- Health Choice Utah: 855-864-1404

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Nexletol® (bempedoic acid), ☐ Nexlizet™ (bempedoic acid/ezetimibe)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Does the member have a documented diagnosis of heterozygous familial hypercholesterolemia or established atherosclerotic cardiovascular disease?	☐	☐	**Please provide documentation**
2. Has the member demonstrated at least 80% compliance with high intensity statin therapy or contraindication/intolerance to ezetimibe and at least two generic statin therapies?	☐	☐	**Please provide documentation**
3. Is the member's fasting LDL-C level > 70mg/dL?	☐	☐	**Please provide documentation**
4. Is the member taking a proprotein convertase substilisin/kexin 9 (PCSK9) inhibitor?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show a decrease in baseline LDL-C level of at least 15% from baseline?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:	
PRESCRIBER CERTIFICATION	
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.	
Physician's Signature:	**Date:**

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Policy: PHARM-MM-099
Origination Date: 01/01/2022
Reviewed/Revised Date: 04/08/2026
Next Review Date: 04/08/2027
Current Effective Date: 05/01/2026

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