Prior Authorization Form

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested authorization(s). Attach additional sheets to this form if necessary.

Please fax the completed PA form and any additional informational sheets to Nirvanahealth at the following fax number: +1(866) 871-8565

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Health Plan Name:		Prescriber Address:	
Patient Insurance Id:			
Patient Date of Birth:		Prescriber Phone:	( )
Patient Phone:		Prescriber Fax:	( )
		Prescriber Specialty:	
		Prescriber DEA:	
		Prescriber NPI:	

Medication & Medical Information	
Requested Drug(s) & Strength(s):	[ ] Nexlizet 180 mg-10 mg tablet
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – Days:	
Expected Length of Therapy:	
Directions:	
Diagnosis and Diagnosis Codes (ICD-10 Standard Codes):	
List drugs used previously to treat the same condition:	
Additional clinical information or history. Please include any relevant test results and/or medical record notes:	

Questionnaire

Q1: I, as the provider or designated representative of the provider, certify and attest that the information provided is complete and accurate and that, upon request, I shall provide any information to RxAdvance that RxAdvance determines is reasonably necessary to verify my responses. (Check only one that apply)

[ ] Yes

[ ] No

Q2: Is the member currently treated with this medication? (Check only one that apply)

[ ] Yes (please list start date of therapy (month/day/year)) _____ (*Required)

[ ] No

Q3: What is the member's diagnosis? (Check only one that apply)

[ ] Heterozygous familial hypercholesterolemia (HeFH)

[ ] Atherosclerotic cardiovascular disease (ASCVD)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____(*Required)

Q4: Is there documentation of positive clinical response to therapy (e.g., reduction in LDL-C levels)? (Check only one that apply)

[ ] Yes (please provide documentation(s) supporting the positive response of the therapy)
_____(*Required)

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q5: Is the member continuing to receive other lipid-lowering therapy (e.g., statins, ezetimibe) at the maximally tolerated dose? (Check only one that apply)

[ ] Yes (please specify drug name, corresponding therapy and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q6: Does the member have a documented inability to take other lipid-lowering therapy (e.g., statins, ezetimibe)? (Check only one that apply)

[ ] Yes (please provide documentation(s) supporting the inability to take other lipid-lowering therapy (e.g., statins, ezetimibe))
_____(*Required)

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q7: What is the member's diagnosis? (Check only one that apply)

[ ] Heterozygous familial hypercholesterolemia (HeFH)

[ ] Atherosclerotic cardiovascular disease (ASCVD)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____(*Required)

Q8: 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)? (Check only one that apply)

[ ] Yes (please specify the LDL-cholesterol value) _____(*Required)

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q9: Member meets which one of the following? (Check only one that apply)

[ ] Family history of myocardial infarction in 1st-degree relative less than 60 years of age,

[ ] Family history of myocardial infarction in 2nd-degree relative less than 50 years of age

[ ] Family history of LDL-C greater than 190 mg/dL in 1st- or 2nd-degree relative

[ ] Family history of FH in 1st- or 2nd-degree relative

[ ] Family history of tendinous xanthomas and/or arcus cornealis in 1st- or 2nd-degree relative

[ ] Other (please provide clinical rationale for the request) _____ (*Required)

Q10: Does the patient have any of the following? (Check only one that apply)

[ ] Functional mutation in the LDL receptor, ApoB, or PCSK9 gene,

[ ] Tendinous xanthomata

[ ] Arcus cornealis before age 45

[ ] Other (please provide clinical rationale for the request) _____ (*Required)

Q11: Does the patient have ASCVD as confirmed by any of the following? (Check only one that apply)

[ ] Acute coronary syndromes

[ ] History of myocardial infarction

[ ] Stable or unstable angina

[ ] Coronary or other arterial revascularization (eg, percutaneous coronary intervention [PCI] or coronary artery bypass graft [CABG] surgery)

[ ] Stroke

[ ] Transient ischemic attack

[ ] Peripheral arterial disease presumed to be of atherosclerotic origin

[ ] Clinically significant coronary heart disease diagnosed by invasive or noninvasive testing (e.g., coronary angiography, stress test using treadmill, stress echocardiography or nuclear imaging)

[ ] Other (please provide clinical rationale for the request) _____ (*Required)

Q12: Does the member have one of the following LDL-C values while on maximally tolerated statin treatment within the last 120 days? (Check only one that apply)

[ ] LDL-C greater than or equal to 70 mg/dL with ASCVD

[ ] LDL-C greater than or equal to 100 mg/dL without ASCVD

[ ] Other (please provide clinical rationale for the request) _____ (*Required)

Q13: Has the member 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? (Check only one that a

[ ] Yes

[ ] No (please provide medical justification for continuation of therapy) _____(*Required)

Q14: Is the member unable to tolerate high-intensity statin as evidenced by one of the following intolerable and persistent (i.e., more than 2 weeks) symptoms? (Check only one that apply)

[ ] Myalgia (muscle symptoms without creatine kinase [CK] elevations)

[ ] Myositis (muscle symptoms with CK elevations < 10 times upper limit of normal [ULN])

[ ] None of the above (please provide clinical rationale for the request)
_____(*Required)

Q15: Has the member been receiving at least 12 consecutive weeks of one moderate-Intensity statin therapy (MIS) [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] treatment and will continue to receive a moderate-Intensity statin at maximally tolerated dose? (Check only one that apply)

[ ] Yes (please specify the drug name, type of response and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] No

Q16: Has the member been receiving at least 12 consecutive weeks of one low-intensity statin therapy (LIS) [i.e., simvastatin 10 mg, pravastatin 10-20 mg, lovastatin 20 mg, fluvastatin 20-40 mg, Livalo (pitavastatin) 1 mg] treatment and will continue to receive a low-intensity statin at maximally tolerated dose? (Check only one that apply)

[ ] Yes (please specify the drug name, type of response and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q17: Is the member 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? (Check only one that apply)

[ ] Myalgia (muscle symptoms without CK elevations)

[ ] Myositis (muscle symptoms with CK elevations less than 10 times ULN)
_____(*Required)

[ ] None of the above (please provide clinical rationale for the request)
_____(*Required)

Q18: Does the member have a labeled contraindications to all statins? (Check only one that apply)

[ ] Yes (please specify drug name(s), corresponding contraindication(s) and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q19: Has the member experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN? (Check only one that apply)

[ ] Yes (please specify the symptoms experienced and the test result(s))
_____(*Required)

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q20: Has the member been receiving at least 12 consecutive weeks of generic ezetimibe therapy as adjunct to maximally tolerated statin therapy? (Check only one that apply)

[ ] Yes (please specify drug name(s) and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q21: Does the member have a history of contraindication or intolerance to ezetimibe? (Check only one that apply)

[ ] Yes (please specify the contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q22: What is the intent of therapy? (Check only one that apply)

[ ] For continuation of prior therapy

[ ] For Initial treatment

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group or its designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.	
Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	