Jefferson Health Plans

# *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 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. 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 patient 18 years of age or older?

☐ Yes ☐ No

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

☐ Yes ☐ No

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

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☐ 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

v2025