

<b>Clinical Policy Title:</b>	bempedoic acid
<b>Policy Number:</b>	RxA.651
<b>Drug(s) Applied:</b>	Nexletol, Nexlizet
<b>Original Policy Date:</b>	6/19/2025
<b>Last Review Date:</b>	12/11/2025
<b>Line of Business Policy Applies to:</b>	All lines of business (except Medicare)

## Criteria

### I. Initial Approval Criteria

#### A. Primary Hyperlipidemia, Established Cardiovascular Disease (CVD), Heterozygous Familial Hypercholesterolemia, High Risk for a CVD Event (must meet all):

1. Documentation of a diagnosis of one of the following (a, b, c, or d):
  - a. Heterozygous familial hypercholesterolemia;
  - b. Primary hyperlipidemia;
  - c. Established CVD (coronary artery disease, symptomatic peripheral arterial disease, cerebrovascular atherosclerotic disease);
  - d. High risk for a CVD event but without established CVD (i, ii, or iii):
    - i. Diabetes mellitus in females over 65 years of age or males over 60 years of age;
    - ii. Reynolds Risk score >30% or a SCORE risk score >7.5% over 10 years;
    - iii. Coronary artery calcium score >400 Agatston units;
2. Patient has been receiving at least 12 weeks of generic ezetimibe therapy unless contraindicated or clinically significant adverse effects are experienced;
3. Documentation of one of the following of LDL-C values within the last 120 days (a or b):
  - a. LDL-C  $\geq$ 55 mg/dL with ASCVD;
  - b. LDL-C  $\geq$ 70 mg/dL without ASCVD;
4. One of the following (a, b, or c):
  - a. Used as adjunct to statin therapy;
  - b. Patient is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes in liver function or muscle function (e.g., creatine kinase);
  - c. Patient has a contraindication to all statins.

#### Approval duration

**All Lines of Business (except Medicare): 12 months**

### II. Continued Therapy Approval

#### A. All Indications in Section I (must meet all):

1. Auto-approval based on lookback functionality within the past 120 days as a proxy for members responding positively to therapy with RxAdvance initial approval.

#### Approval duration

**All Lines of Business (except Medicare): 12 months**

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

**References**

1. Nexletol, Nexlizet. Package Insert (CVD). Esperion Therapeutics, Inc.; 2024. Available at: [NEXLIZET® & NEXLETOL® HCP Information - Official Site](#). Accessed June, 2025.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	6/19/25	6/19/25
Policy reviewed	12/11/2025	12/11/2025