Drug Coverage Policy

Effective Date.....7/15/2025
Coverage Policy Number IP0249
Policy Title.....Nexlizet

Hyperlipidemia – Nexlizet

- Nexlizet® (bempedoic acid and ezetimibe tablets - Esperion)

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

OVERVIEW

Nexlizet contains bempedoic acid, an adenosine triphosphate-citrate lyase inhibitor, and ezetimibe, a cholesterol absorption inhibitor. It is indicated for the following:[1]

- **Primary hyperlipidemia**, including **heterozygous familial hypercholesterolemia** (HeFH), in adults as an adjunct to diet, alone or in combination with other low-density lipoprotein cholesterol (LDL-C) lowering therapies, to reduce LDL-C.

The bempedoic acid component of Nexlizet (marketed as Nexletol® [bempedoic acid tablets]) is indicated for the following:[1]

- To reduce the risk of myocardial infarction (MI) and coronary revascularization in adults who are unable to take recommended statin therapy (including those not taking a statin) with either 1) **established cardiovascular disease** (CVD) or 2) **at high risk for a CVD event but without established CVD**.

The safety and effectiveness of Nexlizet have not been established in pediatric patients.[1]

Clinical Efficacy

CLEAR Outcomes was a randomized, double-blind, placebo-controlled trial involving 13,970 adults, 18 to 85 years of age who were unable or unwilling to take statins due to unacceptable adverse events. Patients had or were at high risk for CVD.[1,2] Patients without established CVD were considered high risk for CVD based on meeting at least one of the following: diabetes mellitus (type 1 or type 2) in females > 65 years of age or males > 60 years of age; a Reynolds Risk score > 30% or a SCORE Risk score > 7.5% over 10 years; or a coronary artery calcium score > 400 Agatston units at any time in the past.[1] Patients were assigned to receive Nexletol or placebo.[1,2] Use of statins at very low doses were permitted, as well as other lipid-lowering therapies (e.g., ezetimibe, bile acid sequestrants, fibrates). The mean patient age was 65 years. In total, 70% of patients had a previous cardiovascular (CV) event (secondary prevention population), whereas 30% of patients were categorized as being in the primary prevention group. In total, 38% of patients were receiving at least one lipid-modifying therapy. At baseline, 23% of patients were utilizing a statin and 12% of patients were on ezetimibe. The mean LDL-C at baseline was 139 mg/dL. The median follow-up was 40.6 months. The mean LDL-C level after 6 months of treatment with Nexletol was 107 mg/dL vs. 136 mg/dL for placebo. The primary endpoint (death from CV causes, nonfatal myocardial infarction [MI], nonfatal stroke, or coronary revascularization) occurred in 11.7% of patients in the Nexletol group vs. 13.3% of patients in the placebo group (P = 0.004). The composite endpoint (death from CV causes, nonfatal stroke, or nonfatal MI) occurred in 8.2% of patients given Nexletol vs. 9.5% of patients in the placebo group (P = 0.006).

Guidelines

Many guidelines are available regarding the treatment of patients with dyslipidemia.[3-11,17-19] For patients with elevated LDL-C, statins are the cornerstone of therapy and recommended first-line to be used at maximally tolerated doses due to the established benefits regarding the reduction of CV risks. Atorvastatin 40 mg to 80 mg once daily (QD) and rosuvastatin 20 mg to 40 mg QD are considered high-intensity statins as they achieve LDL-C lowering of ≥ 50%.

- The **American College of Cardiology (ACC) Expert Consensus Decision Pathway on the Role of Non-Statin Therapies** for LDL-Cholesterol Lowering in the Management of Atherosclerotic Cardiovascular Disease (ASCVD) Risk (2022) make several recommendations.[3] For adults with clinical ASCVD at very high risk (e.g., patients with major ASCVD events, HeFH, diabetes) who are on statin therapy for secondary prevention, the general goal is ≥ 50% LDL-C reduction and an LDL-C < 55 mg/dL (or non-high-density lipoprotein cholesterol [HDL-C] < 85 mg/dL) with maximally tolerated statin therapy. If the above goals are not achieved, the initial non-statin agents recommended include ezetimibe and/or a proprotein convertase subtilisin kexin type 9 (PCSK9) monoclonal antibody (i.e.,

Repatha® [evolocumab subcutaneous injection] or Praluent® [alirocumab subcutaneous injection]). Nexletol can be considered after these therapies.

- The **American Heart Association (AHA)/ACC** guidelines on the management of blood cholesterol (2018) define patients with ACSVD as those with acute coronary syndrome, those with a history of MI, stable or unstable angina or coronary or other revascularizations, stroke, transient ischemic attack, or peripheral arterial disease.[4,5] An LDL-C < 70 mg/dL is recommended for most patients with ASCVD to reduce CV risk. Guidelines and reviews have recognized that patients with an elevated coronary artery calcium or calcification score (e.g., ≥ 300 Agatston units) are at an increased risk of CV events.[13-16]
- The **American Diabetes Association Standards of Care for Diabetes** discuss CV disease and risk management (2025).[8] For patients with diabetes who are 40 to 75 years of age at higher CV risk (including those with one or more ASCVD risk factors), it is recommended to use high-intensity statin therapy to reduce LDL-C by ≥ 50% of baseline and to target an LDL-C of < 70 mg/dL. Also, for patients with diabetes who are 40 to 75 years of age at higher CV risk, especially those with multiple ASCVD risk factors and an LDL-C ≥ 70 mg/dL, it may be reasonable to add ezetimibe or a PCSK9 inhibitor to a maximum tolerated statin. In patients with diabetes intolerant to statin therapy, treatment with Nexletol is recommended to reduce CV event rates as an alternative cholesterol-lowering plan.
- The **ACC/AHA Guideline for the management of Patients with Acute Coronary Syndrome (ACS)** [2025] states that patients who are already on maximally tolerated statin therapy with LDL-C ≥ 70 mg/dL, adding a non statin lipid-lowering agent is recommended to further reduce the risk of a major adverse cardiac event (MACE).[17] Some recommendations also provide for a lower goal LDL-C level (55 to 69 mg/dL).
- Guidelines for **Chronic Coronary Disease from the AHA and ACC** (along with other organizations) [2023] state in such patients who are judged to be at very high risk and on maximally tolerated statin therapy and with an LDL-C ≥ 70 mg/dL, ezetimibe can be beneficial to further reduce the risk of a major adverse coronary event.[9] Patients with chronic coronary disease who are considered to be at very high risk who have an LDL-C ≥ 70 mg/dL who are receiving maximally tolerated statins and ezetimibe, a PCSK9 monoclonal antibody can be beneficial to further reduce the risk of a major adverse coronary event. In patients with chronic coronary disease who are on maximally tolerated statin therapy who have an LDL-C ≥ 70 mg/dL and in whom ezetimibe and a PCSK9 monoclonal antibody are not adequate or are not tolerated, it may be reasonable to add Nexletol.
- The **American Association of Clinical Endocrinology** (AACE) clinical practice guideline on the pharmacologic management of adults with dyslipidemia (2025) make many recommendations.[7] In adults with dyslipidemia who are receiving maximally tolerated statins and have ASCVD or who are at an increased risk for ASCVD but who are not at goal (LDL-C < 70 mg/dL), AACE suggests therapy with Praluent or Repatha. In adults with dyslipidemia who are statin intolerant and have ASCVD or are at increased risk of ASCVD, AACE suggests use of Nexletol in addition to usual care. In adults with dyslipidemia who do not have ASCVD and who may tolerate other lipid-lowering medications, AACE suggests against the use of Nexletol.
- The **International Lipid Expert Panel** has various position papers on the use of lipid-lowering therapy that involve Nexletol (2023 and 2024).[10,18,19] One recommendation is that in patients with statin intolerance, Nexletol monotherapy, or in combination with ezetimibe and other non-statin drugs is recommended to enable patients to achieve therapeutic goals.[10] In primary prevention, Nexletol may be considered for patients at high and very high CV risk who, despite optimally maximally tolerated doses of statins and ezetimibe, are not achieving target LDL-C levels.[10]
- **The AHA** published a scientific statement regarding familial hypercholesterolemia (2015).[11] Key points are that the condition may start early (in childhood or adolescence) and is noted by LDL-C levels ≥ 190 mg/dL. Premature CV disease can result. Diagnosis can be confirmed by genetic testing. The Dutch Lipid Clinic Network criteria and Simon Broome criteria may

also be used which incorporate cholesterol levels, family history, clinical findings, and physical manifestations. Aggressive lipid-lowering therapy is recommended to achieve LDL-C reductions of at least 50%.[11] Other information also provides guidance on the diagnosis of HeFH.[12]

Coverage Policy

POLICY STATEMENT

Prior Authorization is required for benefit coverage of Nexlizet. All approvals are provided for the duration noted below. A patient who has previously met Initial Therapy criteria for Nexlizet for the requested indication under the Coverage Review Department and is currently receiving Nexlizet is only required to meet continuation of therapy criteria (i.e., currently receiving therapy). If past criteria have not been met under the Coverage Review Department and the patient is currently receiving Nexlizet, or is restarting Nexlizet, Initial Therapy criteria must be met.

Nexlizet is considered medically necessary when the following criteria are met:

FDA-Approved Indications

1. **Established Cardiovascular Disease.*** Approve for 1 year if the patient meets ALL of the following (A or B):
   - **A)** Initial Therapy. Approve if the patient meets ALL of the following (i, ii, iii, and iv):
     - **i.** Patient is ≥ 18 years of age; AND
     - **ii.** Patient has had ONE of the following conditions or diagnoses (a, b, c, d, e, or f):
       - **a)** A previous myocardial infarction or a history of an acute coronary syndrome; OR
       - **b)** Angina (stable or unstable); OR
       - **c)** A past history of stroke or transient ischemic attack; OR
       - **d)** Coronary artery disease; OR
       - **e)** Peripheral arterial disease; OR
       - **f)** Patient has undergone a coronary or other arterial revascularization procedure in the past; AND
         Note: Examples include coronary artery bypass graft surgery, percutaneous coronary intervention, angioplasty, and coronary stent procedures.
     - **iii.** Patient meets ONE of the following (a or b):
       - **a)** Patient meets BOTH of the following [(1) and (2)]:
         - **(1)** Patient has tried one high-intensity statin therapy (i.e., atorvastatin ≥ 40 mg daily; rosuvastatin ≥ 20 mg daily [as a single-entity or as a combination product]) for ≥ 8 continuous weeks; AND
         - **(2)** Low-density lipoprotein cholesterol level after this therapy regimen remains ≥ 55 mg/dL; OR
       - **b)** Patient has been determined to be statin intolerant by meeting ONE of the following [(1) or (2)]:
         - **(1)** Patient experienced statin-related rhabdomyolysis; OR
           Note: Statin-induced muscle breakdown that is associated with markedly elevated creatine kinase levels (at least 10 times the upper limit of normal), along with evidence of end organ damage which can include signs of acute renal injury (noted by substantial increases in serum creatinine [Scr] levels [a ≥ 0.5 mg/dL increase in Scr or doubling of the Scr] and/or myoglobinuria [myoglobin present in urine]); OR
         - **(2)** Patient meets ALL of the following [(a), (b), and (c)]:
           - **(a)** Patient experienced skeletal-related muscle symptoms; AND

Note: Examples of skeletal-related muscle symptoms include myopathy (muscle weakness) or myalgia (muscle aches, soreness, stiffness, or tenderness).

(b) The skeletal-muscle related symptoms occurred while receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or combination product); AND

(c) When receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination product), the skeletal-related muscle symptoms resolved upon discontinuation of each respective statin therapy (atorvastatin and rosuvastatin); OR
Note: Examples of skeletal-related muscle symptoms include myopathy and myalgia.

iv. Preferred criteria are met for the as listed in the below table(s).

B) Patient Currently Receiving Nexlizet. Approve if according to the prescriber, the patient has experienced a response to therapy.
Note: Examples of a response to therapy include decreasing low-density lipoprotein cholesterol (LDL-C), total cholesterol, non-high-density lipoprotein (non-HDL-C), or apolipoprotein B levels. Also, if the patient is currently receiving the requested therapy but has not previously received approval of Nexlizet for this specific indication through the Coverage Review Department, review under criteria for Initial Therapy. If the patient is restarting therapy with Nexlizet, Initial Therapy criteria must be met.

2. Heterozygous Familial Hypercholesterolemia (HeFH).* Approve for 1 year if the patient meets ONE of the following (A or B):

A) Initial Therapy. Approve if the patient meets ALL of the following (i, ii, iii, or iv):

i. Patient is ≥ 18 years of age; AND

ii. Patient meets ONE of the following (a, b, or c):

a) Patient has an untreated low-density lipoprotein cholesterol (LDL-C) level ≥ 190 mg/dL (prior to treatment with antihyperlipidemic agents); OR

b) The diagnosis has been confirmed by genetic testing; OR
Note: Examples include pathogenic variants at the low-density lipoprotein receptor (LDLR), apolipoprotein B (APOB), proprotein convertase subtilisin kexin type 9 (PCSK9), or low-density lipoprotein receptor adaptor protein 1 (LDLRAP1) gene.

c) Patient has been diagnosed with heterozygous familial hypercholesterolemia by meeting ONE of the following diagnostic criteria thresholds [(1) or (2)]:

(1) Prescriber confirms that the Dutch Lipid Network criteria score was > 5; OR

(2) Prescriber confirms that Simon Broome criteria met the threshold for "definite" or "possible (or probable)" familial hypercholesterolemia; AND

iii. Patient meets ONE of the following (a or b):

a) Patient meets BOTH of the following [(1) and (2)]:

(1) Patient has tried one high-intensity statin therapy (i.e., atorvastatin ≥ 40 mg daily; rosuvastatin ≥ 20 mg daily [as a single-entity or as a combination product]) for ≥ 8 continuous weeks; AND

(2) LDL-C level after this treatment regimen remains ≥ 70 mg/dL; OR

b) Patient has been determined to be statin intolerant by meeting ONE of the following [(1) or (2)]:

(1) Patient experienced statin-related rhabdomyolysis; OR
Note: Statin-induced muscle breakdown that is associated with markedly elevated creatine kinase levels (at least 10 times the upper limit of normal), along with evidence of end organ damage which can include signs of acute renal injury (noted by substantial increases in serum creatinine [Scr] levels [a ≥ 0.5 mg/dL increase in Scr or doubling of the Scr] and/or myoglobinuria [myoglobin present in urine]); OR

(2) Patient meets ALL of the following [(a), (b), and (c)]:
(a) Patient experienced skeletal-related muscle symptoms; AND
Note: Examples of skeletal-related muscle symptoms include myopathy (muscle weakness) or myalgia (muscle aches, soreness, stiffness, or tenderness).
(b) The skeletal-muscle related symptoms occurred while receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or combination product); AND
(c) When receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination product), the skeletal-related muscle symptoms resolved upon discontinuation of each respective statin therapy (atorvastatin and rosuvastatin); OR
Note: Examples of skeletal-related muscle symptoms include myopathy and myalgia.

iv. Preferred criteria are met for the as listed in the below table(s).

B) Patient Currently Receiving Nexlizet. Approve if according to the prescriber, the patient has experienced a response to therapy.
Note: Examples of a response to therapy include decreasing low-density lipoprotein cholesterol (LDL-C), total cholesterol, non-high-density lipoprotein (non-HDL-C), or apolipoprotein B levels. Also, if the patient is currently receiving the requested therapy but has not previously received approval of Nexlizet for this specific indication through the Coverage Review Department, review under criteria for Initial Therapy. If the patient is restarting therapy with Nexlizet, Initial Therapy criteria must be met.

3. Primary Hyperlipidemia.* Approve for 1 year if the patient meets ONE of the following (A or B):
Note: This is not associated with established cardiovascular disease or heterozygous familial hypercholesterolemia (HeFH) and may be referred to as combined hyperlipidemia, hypercholesterolemia (pure, primary), dyslipidemia, or increased/elevated low-density lipoprotein cholesterol (LDL-C) levels.

A) Initial Therapy. Approve if the patient meets ALL of the following (i, ii, iii, and iv):
i. Patient is ≥ 18 years of age; AND
ii. Patient meets ONE of the following (a or b):
a) Patient has a coronary artery calcium or calcification score ≥ 300 Agatston units; OR
b) Patient has diabetes; AND
iii. Patient meets ONE of the following (a or b):
a) Patient meets BOTH of the following [(1), (2), and (3)]:
(1) Patient has tried one high-intensity statin therapy (i.e., atorvastatin ≥ 40 mg daily; rosuvastatin ≥ 20 mg daily [as a single-entity or as a combination product]); AND
(2) LDL-C level after this treatment regimen remains ≥ 70 mg/dL; OR
b) Patient has been determined to be statin intolerant by meeting ONE of the following [(1) or (2)]:
(1) Patient experienced statin-related rhabdomyolysis; OR
Note: Rhabdomyolysis is statin-induced muscle breakdown that is associated with markedly elevated creatine kinase levels (at least 10 times the upper limit of normal), along with evidence of end organ damage which can include signs of acute renal injury (noted by substantial increases in serum creatinine [Scr] levels [a ≥ 0.5 mg/dL increase in Scr or doubling of the Scr] and/or myoglobinuria [myoglobin present in urine]).
(2) Patient meets ALL of the following [(a), (b), and (c)]:
(a) Patient experienced skeletal-related muscle symptoms; AND

Note: Examples of skeletal-related muscle symptoms include myopathy (muscle weakness) or myalgia (muscle aches, soreness, stiffness, or tenderness).

(b) The skeletal-muscle related symptoms occurred while receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or combination product); AND

(c) When receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination product), the skeletal-related muscle symptoms resolved upon discontinuation of each respective statin therapy (atorvastatin and rosuvastatin); OR
Note: Examples of skeletal-related muscle symptoms include myopathy and myalgia.

iv. Preferred product criteria are met for the product(s) as listed in the below table(s).

B) Patient Currently Receiving Nexlizet. According to the prescriber, the patient has experienced a response to therapy.
Note: Examples of a response to therapy include decreasing low-density lipoprotein cholesterol (LDL-C), total cholesterol, non-high-density lipoprotein (non-HDL-C), or apolipoprotein B levels. Also, if the patient is currently receiving the requested therapy but has not previously received approval of Nexletol for this specific indication through the Coverage Review Department, review under criteria for Initial Therapy. If the patient is restarting therapy with Nexletol, Initial Therapy criteria must be met.

Note:
* A patient may have a diagnosis that pertains to more than one indication, therefore, consider review under different approval conditions, if applicable (e.g., a patient with heterozygous familial hypercholesterolemia may have established cardiovascular disease, a patient with primary hyperlipidemia may have heterozygous familial hypercholesterolemia).

Employer Plans:

Product	Criteria
Nexlizet (bempedoic acid and ezetimibe tablet)	**Value /Advantage/Total Savings Drug List Plans:** Approve if the patient has tried a Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) inhibitor product [e.g., Praluent or Repatha].

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Conditions Not Covered

Nexlizet for any other use is considered not medically necessary. Criteria will be updated as new published data are available.

References

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APPENDIX A

Simon Broome Register Diagnostic Criteria.[11,12]

Definite Familial Hypercholesterolemia
Raised cholesterol
--Total cholesterol greater than 6.7 mmol/L (260 mg/dL) or LDL-C > 4.0 mmol/L (155 mg/dL) in a child < 16 years; OR
--Total cholesterol > 7.5 mmol/L (290 mg/dL) or LDL-C > 4.9 mmol/L (190 mg/dL) in an adult (aged > 16 years);
AND
--Tendon xanthomas in the patient or in a first (parent, sibling, or child) or second-degree relative (grandparent, aunt, or uncle);
OR
DNA-based evidence of LDL-receptor, familial defective APOB, or PCSK9 mutation.
Possible (or Probable) Familial Hypercholesterolemia
Raised cholesterol
--Total cholesterol greater than 6.7 mmol/L (260 mg/dL) or LDL-C > 4.0 mmol/L (155 mg/dL) in a child < 16 years; OR
--Total cholesterol > 7.5 mmol/L (290 mg/dL) or LDL-C > 4.9 mmol/L (190 mg/dL) in an adult (aged > 16 years);
AND
Family history of premature myocardial infarction younger than 50 years of age in second-degree relative or younger than 60 years of age in first-degree relative;
OR
Raised cholesterol
--Total cholesterol greater than 6.7 mmol/L (260 mg/dL) or LDL-C > 4.0 mmol/L (155 mg/dL) in a child < 16 years; OR
--Total cholesterol > 7.5 mmol/L (290 mg/dL) or LDL-C > 4.9 mmol/L (190 mg/dL) in an adult (aged > 16 years);
AND
Family history of raised cholesterol > 7.5 mmol (290 mg/dL) in adult first-degree or second-degree relative or > 6.7 mmol/L (260 mg/dL) in child or sibling aged < 16 years.

LDL-C – Low-density lipoprotein cholesterol; LDL – Low-density lipoprotein; APOB – Apolipoprotein B; PCSK9 – Proprotein convertase subtilisin kexin type 9.

APPENDIX B.

Dutch Lipid Network Criteria.[11,12]

Criteria	**Score**
Family History	
First-degree relative with known premature coronary and/or vascular disease (men < 55 years, women < 60 years)	1
First degree relative with known LDL-C > 95th percentile for age and sex	1
First-degree relative with tendon xanthomata and/or arcus cornealis, OR	2
Children aged < 18 years with LDL-C > 95th percentile for age and sex	2
Clinical History	
Patient with premature CAD (age as above)	2
Patient with premature cerebral or peripheral vascular disease (age as above)	1
Physical Examination	
Tendon xanthomas	6
Arcus cornealis at age < 45 years	4

LDL-C	
LDL-C ≥ 8.5 mmol/L (330 mg/dL)	8
LDL-C 6.5 to 8.4 mmol/L (250 to 329 mg/dL)	5
LDL-C 5.0 to 6.4 mmol/L (190 to 249 mg/dL)	3
LDL-C 4.0 to 4.9 mg/dL (155 to 189 mg/dL)	1
DNA analysis	
Functional mutation LDLR, APOB or PCSK9 gene	8
Stratification	**Total score**
Definite familial hypercholesterolemia	> 8
Probable familial hypercholesterolemia	6 to 8
Possible familial hypercholesterolemia	3 to 5
Unlikely familial hypercholesterolemia	< 3

LDL-C – Low-density lipoprotein cholesterol; CAD – Coronary artery disease; LDLR – Low-density lipoprotein receptor; APOB – Apolipoprotein B; PCSK9 – Proprotein convertase subtilisin kexin type 9.

Revision Details

Type of Revision	Summary of Changes	Date
Annual Revision	**Updated** coverage policy title from *Bempedoic Acid and Ezetimibe to Hyperlipidemia – Nexlizet*. **<u>All Indications:</u>** **Clarified** "Initial Therapy" versus "Currently Receiving Nexlizet" criteria and added additional examples of what is considered a response to therapy. **Removed** "Use is adjunctive to diet and maximally tolerated statin therapy [unless contraindicated or intolerant]." **Updated** the statin intolerance criteria, to clearly define what is considered statin intolerant, with notes and examples also included. **<u>Established Cardiovascular Disease:</u>** **Changed** the name of the indication to as stated (previously "Atherosclerotic Cardiovascular Dissease"). **Changed** the requirement that the low-density lipoprotein cholesterol level after treatment with one high-intensity statin therapy be ≥ 70 mg/dL to ≥ 55 mg/dL [based on guideline update]. **<u>Primary Hyperlipidemia:</u>** **Added** clinical criteria for coverage of use.	8/15/2024
Annual Revision	**Heterozygous Familial Hypercholesterolemia (HeFH):** For <u>Initial Therapy</u>, the phrase "phenotypic confirmation of heterozygous familial	7/15/2025

	hypercholesterolemia" was replaced with "The diagnosis has been confirmed by genetic testing". Also, "apo B" was changed to "APOB".	

The policy effective date is in force until updated or retired.