Montana Healthcare Programs Prior Authorization Request Form for Use of JUXTAPI® (lomitapide)

Member Name: | DOB: | Date:
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Member ID: | Prescriber Phone:
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Prescriber Name/Specialty (if applicable): | Prescriber Fax:
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Requested Drug/Dose/Directions:

Please complete below information for applicable situation, **Initiation** or **Continuation** of therapy:

**☐ INITIATION OF THERAPY**

1. **Member is 18 years of age or older:** ☐ Yes ☐ No
2. **Member must have a diagnosis of homozygous familial hypercholesterolemia (HoFH):** ☐ Yes ☐ No
3. **Medication is being prescribed by or in consultation with a cardiologist, endocrinologist or lipidologist:**
   ☐ Yes ☐ No  
   **Action required:** If not in a specialty clinic or written by a specialist, information on annual consult with an appropriate specialist is required:
   
   **Name of specialist:** ____________________________  **Contact date:** ________________

4. **Member has low-density lipoproteins (LDL)-cholesterol level equal to or greater than 70mg/dl:**
   ☐ Yes ☐ No  
   **Please provide baseline LDL:** ____________________________  **Date:** ________________

   **Note:** If LDL levels can not be determined due to high triglycerides, direct LDL-C testing is required.

5. **Member has trialed at least two high-intensity statins at maximum tolerated doses, for at least 12 weeks:**
   **First statin used/dose:** ____________________________  **Statin dates:** ________________
   **Reason for discontinuation:**______________________________
   **Second statin used/dose:** ____________________________  **Statin dates:** ________________
   **Reason for discontinuation:**______________________________

6. **Member has trialed ezetimibe for at least 12 weeks and it has been been ineffective or contraindicated:**
   ☐ Yes ☐ No  
   **Dates of use:** ________________  **Reason for discontinuation:** ________________
7. Member will continue receiving a lipid lowering therapy and continue in combination with Juxtapid®:
   □ Yes  □ No

   **Drug name and dose:** 
   
   **If no, please indicate why:**

8. Member has trialed a PCSK-0 Inhibitor (Praluent/Repatha) for at least 12 weeks and has been ineffective or contraindicated:
   □ Yes  □ No

   **Dates of use:**  
   **Reason for discontinuation:**

**LIMITATIONS:**

Maximum dose allowed: 60mg daily

**Initial authorization will be granted for 6 months.**

☐ CONTINUATION OF THERAPY

1. Member has been adherent to Juxtapid® (will be verified through claims history):
   □ Yes  □ No

2. Member has been adherent to all additional lipid lowering agents the member was taking at the initiation of Juxtapid® (will be verified through claims history):
   □ Yes  □ No

3. Member has demonstrated positive clinical improvement (i.e. reduction in LDL-C):
   □ Yes  □ No

   **Action required:** Please attach lab work.

4. Annual specialist consult attached if prescriber is not a specialist:
   □ Yes  □ No  □ N/A prescriber is a specialist

**LIMITATIONS:**

Maximum dose allowed: 60mg daily

**Reauthorization will be issued for 1 year.**

Please complete form, including required attachments, and fax to Drug Prior Authorization Unit at 1-800-294-1350.

06/2022