Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health

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

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty (*if applicable*):	Prescriber Fax:	
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 omozygous 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-desnity 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 ineffecitive 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