maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST
Juxtapid

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. ☐ Yes ☐ No Is the requested medication being used concurrently with Praluent or Repatha?
2. ☐ Yes ☐ No Is the requested medication being prescribed by, or in consultation with, a cardiologist; an endocrinologist; or a physician who focuses in the treatment of cardiovascular (CV) risk management and/or lipid disorders?
3. What is the indication or diagnosis?
   - ☐ Homozygous familial hypercholesterolemia (HoFH) – **Please answer questions 4 - 16**
   - ☐ Heterozygous familial hypercholesterolemia (HeFH)
   - ☐ Other forms of hyperlipidemia (for example, primary hyperlipidemia, mixed dyslipidemia)
   - ☐ All other indications or diagnoses (Please specify): _____
4. ☐ Yes ☐ No Does the patient have genetic confirmation of two mutant alleles 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 locus?
5. ☐ Yes ☐ No Does the patient have an untreated LDL-C level greater than 500 mg/dL (that is, prior to treatment with antihyperlipidemic agents)?
6. ☐ Yes ☐ No Does the patient have a treated LDL-C level of 300 mg or greater (that is, after treatment with antihyperlipidemic agents but prior to agents such as Repatha)?
7. ☐ Yes ☐ No Does the patient have clinical manifestations of HoFH? Note: Examples of clinical manifestations of HoFH are cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas or xanthelasma.
8. ☐ Yes ☐ No Has the patient tried Repatha?
9. ☐ Yes ☐ No Is the patient known to have two LDL-receptor negative alleles?
10. ☐ Yes ☐ No Has the patient experienced inadequate efficacy or significant intolerance to Repatha, according to the prescriber?
11. ☐ Yes ☐ No Has the patient tried one high-intensity statin therapy (that is, atorvastatin 40 mg or

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		greater daily; rosuvastatin 20 mg or greater daily [as a single-entity or as a combination product]) for at least 8 weeks continuously?
12.	☐ Yes ☐ No	Does the patient's low-density lipoprotein cholesterol (LDL-C) level after this treatment regimen remain greater than or equal to 70 mg/dL?
13.	☐ Yes ☐ No	Has the patient been determined to be statin intolerant by experiencing statin-related Rhabdomyolysis?
14.	☐ Yes ☐ No	Has the patient been determined to be statin intolerant by experiencing skeletal-related muscle symptoms?
15.	☐ Yes ☐ No	Did the skeletal-related muscle symptoms (for example, myopathy or myalgia) occur while receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination products)?
16.	☐ Yes ☐ No	When receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination products) did the skeletal-related muscle symptoms (for example, myopathy or myalgia) resolve upon discontinuation of each respective statin therapy?

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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If you have any questions, call: 800-753-2851