maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Juxtapid

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1	Is the patient greater than or equal to 18 year(s) of age? [If no, no further questions.]	Yes	No
2	Is the requested medication being used concurrently with Praluent or Repatha? [If yes, no further questions.]	Yes	No
3	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? [If no, no further questions.]	Yes	No
4	What is the diagnosis or indication?		

If you have any questions, call:
1-888-258-8250

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	[] Homozygous familial hypercholesterolemia (HoFH) (If checked, go to 5)		
	[] Heterozygous familial hypercholesterolemia (HeFH) (If checked, no further questions)		
	[] Other forms of hyperlipidemia (for example, primary hyperlipidemia, mixed dyslipidemia) (If checked, no further questions)		
	[] Other (If checked, no further questions)		
5	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? [If yes, skip to question 9.]	Yes	No
6	Does the patient have an untreated LDL-C level greater than 500 mg/dL (that is, prior to treatment with antihyperlipidemic agents)? [If yes, skip to question 9.]	Yes	No
7	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)? [If yes, skip to question 9]	Yes	No
8	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.] [If no, no further questions.]	Yes	No
9	Has the patient tried Repatha? [If yes, skip to question 11.]	Yes	No
10	Is the patient known to have two LDL-receptor negative alleles? [If yes, skip to question 12.] [If no, no further questions.]	Yes	No
11	Has the patient experienced inadequate efficacy or significant intolerance to Repatha, according to the prescriber? [If no, no further questions.]	Yes	No
12	Has the patient tried one high-intensity statin therapy (that is, atorvastatin 40 mg or greater daily; rosuvastatin 20 mg or greater daily [as a single-entity or as a combination product]) for at least 8 weeks continuously? [If no, skip to question 14.]	Yes	No
13	Does the patient's low-density lipoprotein cholesterol (LDL-C) level after this treatment regimen remain greater than or equal to 70 mg/dL? [If yes, no further questions.]	Yes	No
14	Has the patient been determined to be statin intolerant by experiencing statin-	Yes	No

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	related rhabdomyolysis? [Note: statin-induced muscle breakdown that is associated with markedly elevated creatine kinase (CK) 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 [greater than or equal to 0.5 mg/dL increase in Scr or doubling of the Scr]) and/or myoglobinuria (myoglobin present in urine).] [If yes, no further questions.]		
15	Has the patient been determined to be statin intolerant by experiencing skeletal-related muscle symptoms? [NOTE: Examples of skeletal-related muscle symptoms include myopathy (muscle weakness) or myalgia (muscle aches, soreness, stiffness, or tenderness).] [If no, no further questions.]	Yes	No
16	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)? [If no, no further questions.]	Yes	No
17	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 (atorvastatin AND rosuvastatin)?	Yes	No

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: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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