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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is the request an INITIAL or CONTINUATION of therapy?

[] Initial (If checked, go to 7)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 7.]

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3	Has the patient been receiving medication samples of Juxtapid? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. [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.] [If no, no further questions.]	Yes	No
7	What is the diagnosis or indication? [] Homozygous familial hypercholesterolemia (HoFH) (If checked, go to 8) [] Other (If checked, no further questions)		
8	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
9	Is the requested medication being used concurrently with Praluent or Repatha? [If yes, no further questions.]	Yes	No
10	Has documentation been submitted to confirm the patient meets ONE of the following? [] Phenotypic confirmation of homozygous familial hypercholesterolemia [Note: Examples include pathogenic variants at the low-density lipoprotein receptor (LDLR), apolipoprotein B (apo B), proprotein convertase subtilisin kexin type 9 (PCSK9), or low-density lipoprotein receptor adaptor protein 1 (LDLRAP1) gene] (If checked, go to 13) [] Untreated low-density lipoprotein cholesterol (LDL-C) level greater than 500 mg/dL and triglyceride TG less than 300 mg/dL [Note: Untreated refers to prior therapy with any antihyperlipidemic agent] (If checked, go to 12) [] Treated LDL-C level greater than or equal to 300 mg/dL [Note: Treated refers to after therapy with at least one antihyperlipidemic agent.] (If checked, go to 11)		

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[] Other (If checked, no further questions)

11	Has documentation been submitted to confirm that the patient had clinical manifestation of homozygous familial hypercholesterolemia before 10 years of age? ACTION REQUIRED: Submit supporting documentation. [Note: Clinical manifestations of homozygous familial hypercholesterolemia are cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas, or xanthelasma.] [If yes, skip to question 13.]	Yes	No
12	Has documentation been submitted to confirm that at least one parent of the patient had untreated LDL-C levels or total cholesterol levels consistent with familial hypercholesterolemia? ACTION REQUIRED: Submit supporting documentation. [Note: An example of familial hypercholesterolemia is an untreated low-density LDL-C level greater than or equal to 190 mg/dL and/or an untreated total cholesterol level greater than 250 mg/dL.] [If no, no further questions.]	Yes	No
13	Has documentation been submitted that the patient has had a treatment failure with AT LEAST 1 high-intensity statin therapy for AT LEAST 8 weeks continuously OR 1 high-intensity statin WITH ezetimibe (as a single-entity or as a combination product) for at least 8 continuous weeks unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions]	Yes	No
14	Has documentation been submitted to confirm that the patient's LDL-C level remains greater than or equal to 70 mg/dL after statin with or without Zetia therapy? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	What is the patient's age? [] 2 to 8 years of age (If checked, go to 19) [] 8 to less than 10 yrs of age (if checked, go to 16) [] 10 years of age or older (If checked, go to 17)		
16	Has documentation been submitted to confirm the patient has had a treatment failure with a PCSK9 inhibitor (i.e., Praluent) for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 18.] [If no, no further questions.]	Yes	No
17	Has documentation been submitted to confirm the patient has had a treatment	Yes	No

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	failure with a PCSK9 inhibitor (i.e., Repatha or Praluent) for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]		
18	Has documentation been submitted to confirm that the patient's LDL-C level remains greater than or equal to 70 mg/dL after PCSK9 inhibitor therapy? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
19	Has documentation been submitted to confirm that the patient has had baseline liver function tests? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
20	Does the provider attest that Juxtapid will not be used concurrently with the medication, Evkeeza? [If no, no further questions]	Yes	No
21	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
22	Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing: 5 mg once daily; after at least 2 weeks of therapy, may increase to 10 mg once daily.]	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

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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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