health information designs

Juxtapid
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Juxtapid must meet the following criteria:

- Patient must have a diagnosis of Homozygous Familial Hypercholesterolemia (HoFH)
- Patient must be 18 years of age or older
- Patient's LDL is >130 mg/dL after a 90-day trial of combined therapy with either Crestor ≥20 mg or atorvastatin ≥ 40 mg plus another lipid lowering agent
- Patient meets one of the following:
  - Has genetic confirmation of 2 mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus
  - Has an untreated LDL and total cholesterol level of > 500 mg/dl or >300 mg/dl with cutaneous or tendon xanthoma before 10 years of age
  - Has an untreated LDL level consistent with HeFH in both parents

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		

Patient's Current LDL:

Does the patient have genetic confirmation of 2 mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus?
□ YES □ NO

Untreated LDL and total cholesterol level of > 500 mg/dl or >300 mg/dl with cutaneous or tendon xanthoma before 10 years of age?
□ YES □ NO

Does the patient have an untreated LDL level consistent with HeFH in both parents?
□ YES □ NO

List all failed medications (drug name, date of trial, reason for failure):

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #