Juxtapid (lomitapide)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Homozygous familial hypercholesterolemia ☐ Other Diagnosis_____ICD-10 Code(s):_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Does the patient have a diagnosis of homozygous familial hypercholesterolemia (HoFH)?* ☐ **Yes** ☐ **No**
Please submit copies of initial history and physical OR initial consultation, including (a) clinical course (and, if applicable, documentation of cardiovascular disease before age 20 while patient was untreated) and (b) family history specifically relating to lipid disorders and cardiovascular events.

Has the patient undergone genetic testing to confirm tw o mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus?* ☐ **Yes** ☐ **No** ***Please provide documentation.***

Has the patient undergone cellular testing to demonstrate reduced LDL receptor activity in fibroblasts/lymphocytes equaling 20% or less of the normal activity?* ☐ **Yes** ☐ **No** ***Please provide documentation.***

Does the patient have an untreated LDL-C level of > 400mg/dL?* ☐ **Yes** ☐ **No**
Please provide documentation.

Do both of the patient's parents have an elevated (> 250mg/dL) total cholesterol or LDL-C before lipid-low ering therapy consistent with heterozygous familial hypercholesterolemia? ☐ **Yes** ☐ **No**

Do both of the patient's parents have a history of early vascular disease (men < 55 years of age, w omen < 60 years of age? ☐ **Yes** ☐ **No**

Did the patient have cutaneous or tender xanthoma(s) before the age of 10?* ☐ **Yes** ☐ **No**
Please provide documentation.

Has the patient had a trial and failure of combined therapy using LDL apheresis, high dose statins and cholesterol absorption inhibitors? ☐ **Yes** ☐ **No** ***Please provide documentation.***

Does the patient have a serum creatinine level from the past 12 months equaling 2.5mg/dL or less?* ☐ **Yes** ☐ **No**
Please provide documentation.

Does the patient have a serum aminotransferase level from the past 12 months equaling less than three times the upper limit of normal?* ☐ **Yes** ☐ **No**
Please submit documentation, along with the normal range listed.

Does the patient have congestive failure? □ Yes □ No

Does the patient have a history of cancer within the past 5 years? □ Yes □ No

Does the patient have a history of drug or alcohol abuse? □ Yes □ No

Reauthorization:
If this is a reauthorization request, answerthe following question:
Has the patient show n LDL reduction in response to treatment?* □ Yes □ No
Please provide chart documentation (i.e., chart notes) supporting this information.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811