



# 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](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:
<input type="checkbox"/> NEW THERAPY <input type="checkbox"/> RENEWAL		IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

*Continued on next page.*





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MEMBER'S LAST NAME: \_\_\_\_\_ MEMBER'S FIRST NAME: \_\_\_\_\_

<b>1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?</b> <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
<b>MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):</b>  	<b>DURATION OF THERAPY (SPECIFY DATES):</b>  	<b>RESPONSE/REASON FOR FAILURE/ALLERGY:</b>  
<b>2. LIST DIAGNOSES:</b> <input type="checkbox"/> Homozygous familial hypercholesterolemia <input type="checkbox"/> Other Diagnosis _____ ICD-10 Code(s): _____		<b>ICD-10:</b>  
<b>3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.</b>		
<p><b>Clinical Information:</b></p> <p>Does the patient have a diagnosis of homozygous familial hypercholesterolemia (HoFH)?* <input type="checkbox"/> Yes <input type="checkbox"/> No  <i>*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.</i></p> <p>Has the patient undergone genetic testing to confirm two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus?* <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please provide documentation.</i></p> <p>Has the patient undergone cellular testing to demonstrate reduced LDL receptor activity in fibroblasts/lymphocytes equaling 20% or less of the normal activity?* <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please provide documentation.</i></p> <p>Does the patient have an untreated LDL-C level of &gt; 400mg/dL?* <input type="checkbox"/> Yes <input type="checkbox"/> No  <i>*Please provide documentation.</i></p> <p>Do both of the patient's parents have an elevated (&gt; 250mg/dL) total cholesterol or LDL-C before lipid-lowering therapy consistent with heterozygous familial hypercholesterolemia? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do both of the patient's parents have a history of early vascular disease (men &lt; 55 years of age, women &lt; 60 years of age)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Did the patient have cutaneous or tender xanthoma(s) before the age of 10?* <input type="checkbox"/> Yes <input type="checkbox"/> No  <i>*Please provide documentation.</i></p> <p>Has the patient had a trial and failure of combined therapy using LDL apheresis, high dose statins and cholesterol absorption inhibitors? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please provide documentation.</i></p> <p>Does the patient have a serum creatinine level from the past 12 months equaling 2.5mg/dL or less?* <input type="checkbox"/> Yes <input type="checkbox"/> No  <i>*Please provide documentation.</i></p> <p>Does the patient have a serum aminotransferase level from the past 12 months equaling less than three times the upper limit of normal?* <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		





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**\*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, answer the 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?**

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**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:** \_\_\_\_\_

**CONFIDENTIALITY NOTICE:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**FAX THIS FORM TO: 800-424-7640**

**MAIL REQUESTS TO:** Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.  
 4801 E. Washington Street, Phoenix, AZ 85034  
 Phone: 877-228-7909

