

JUXTAPID (lomitapide) and KYNAMRO (mipomersen) PRIOR AUTHORIZATION FORM

- Please submit all requested documentation with this form. Incomplete documentation may delay the processing of this request.
- Prior authorization guidelines and quantity limits may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – Lipotropics, Other and Quantity Limits/Daily Dose Limits accessible on the Department's Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request:	Prescriber name:		
<input type="checkbox"/> Renewal request	PA# _____	_____			
Name of office contact:			Specialty:		
Contact's phone number:			State license #:		
LTC facility contact/phone:			NPI:	MA Provider ID#:	
RECIPIENT INFORMATION			Street address:		
Recipient Name:			Suite #:	City/state/zip:	
Recipient ID#:	DOB:	Phone:	Fax:		

CLINICAL INFORMATION

Medication requested:	<input type="checkbox"/> Kynamro 200 mg syringe	<input type="checkbox"/> Juxtapid _____ mg capsule
Dose/directions:	Quantity:	Refills:
Diagnosis:	Dx code (<i>required</i>):	

INITIAL REQUESTS

1. Check all options that apply to the Recipient and submit documentation for each, including chart notes, test results, and medication history.
- diagnosis of homozygous familial hypercholesterolemia (HoFH) supported by medical & family history, cholesterol panel, labs, etc
- has a goal LDL-C of _____ mg/dL (document goal) based on cardiovascular risk
- requested medication is prescribed by or in consultation with a physician specializing in metabolic lipid disorders (submit documentation of consultation)
- prescriber is enrolled in the drug-specific REMS program
- history of trial and failure, contraindication, or intolerance of the following standard lipid lowering drug classes at therapeutic doses
- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> bile acid sequestrants (ex. cholestyramine, Welchol) | <input type="checkbox"/> fibrates (ex. fenofibrate, gemfibrozil) | <input type="checkbox"/> statins |
| <input type="checkbox"/> ezetimibe (Zetia) | <input type="checkbox"/> niacins (ex. Niaspan) | <input type="checkbox"/> other: _____ |
- will be taking the requested medication in addition to therapeutic doses of agents in the following lipid lowering drug classes
- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> bile acid sequestrants (ex. cholestyramine, Welchol) | <input type="checkbox"/> fibrates (ex. fenofibrate, gemfibrozil) | <input type="checkbox"/> statins |
| <input type="checkbox"/> ezetimibe (Zetia) | <input type="checkbox"/> niacins (ex. Niaspan) | <input type="checkbox"/> other: _____ |
- has been counseled regarding lipid-lowering lifestyle interventions, including physical activity and heart-healthy diet
- has documentation of baseline liver function tests, including ALT, AST, alkaline phosphatase, total bilirubin
- does not have moderate to severe liver impairment, active liver disease, or unexplained persistent elevations of transaminases
- this request is for JUXTAPID and
- if female of child-bearing potential, is NOT pregnant
- is NOT taking a medication that is a moderate or strong CYP3A4 inhibitor (submit medication list)

RENEWAL REQUESTS

1. Check all options that apply to the Recipient and submit documentation for each, including chart notes, test results, and medication history.
- has a documented decrease in LDL-C since starting the requested medication
- has documentation of routine liver function tests (LFTs) since starting the requested medication (ALT, AST, alkaline phosphatase, total bill)
- this request is for JUXTAPID and
- if female of child-bearing potential, is NOT pregnant
- is NOT taking a medication that is a moderate or strong CYP3A4 inhibitor (submit medication list)

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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