Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Juxtapid® (lomitapide)

Member

Last Name: _____ First Name: _____
ID #: _____ DOB: _____ Gender: _____
Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____
Provider Address: _____
Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product:
☐ Juxtapid 5 mg tablet
☐ Juxtapid 10 mg tablet
☐ Juxtapid 20 mg tablet

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

1. Diagnosis of homozygous familial hypercholesterolemia (HoFH)
2. Must be prescribed by a cardiologist, lipidologist, endocrinologist, or geneticist
3. Must first try Repatha
4. History of two of the following, unless contraindicated:
    - Atorvastatin
    - Crestor
    - Cholestyramine
    - Niacin ER

Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

All fields must be complete and legible for review. Your office will receive a response via fax.
Updated 01/2017
Last reviewed 05/2018

Priority Health Precertification Documentation

A. What is the patient's diagnosis?

- ☐ homozygous familial hypercholesterolemia (HoFH)
- ☐ *Other – the patient's condition is:* _____

B. Which of the following has the patient tried (must try two for approval)?

- ☐ Atorvastatin Dates of use: _____
- ☐ Crestor Dates of use: _____
- ☐ Cholestyramine Dates of use: _____
- ☐ Niacin ER Dates of use: _____
- ☐ None of the above

C. Has the patient tried Repatha?

- ☐ Yes Dates of use: _____
- ☐ No

D. What is the patient's serum LDL level?

Level: _____ mg/dL Date: _____

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Juxtapid likely be the most effective option for this patient?

- ☐ No
- ☐ Yes, because:_____

_____

_____

If the patient is currently using Juxtapid, would changing the patient's current regimen likely result in adverse effects for the patient?

- ☐ No
- ☐ Yes, because:_____

_____

_____

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