carolina complete health

Pharmacy Request for Prior Approval - Juxtapid or Kynamro

Recipient Information

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Prescriber Information

7. Prescribing Provider #:_____ NPI: ☐ *or* Atypical: ☐
8. Prescriber DEA #: _____
Requester Contact Information
Name:_____ Phone #:_____ Ext:_____

Drug Information

9. Drug Name:_____ 10. Strength: _____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐ Other:_____

Clinical Information

Request for Non-Preferred Drug:

1. Has the recipient been diagnosed with homozygous familial hypercholesterolemia (HoFH)? ☐ Yes ☐ No
2. Is the recipient enrolled in the Juxtapid or Kynamro REMS program? ☐ Yes ☐ No
3. Is the recipient at least 18 years old or older? ☐ Yes ☐ No
4. Is the recipient female? ☐ Yes ☐ No (if Yes, then answer 4a; if No then move to question 5)
   4a. If female, has a negative pregnancy test been obtained? ☐ Yes ☐ No
5. Has a measurement of the recipient's ALT, AST, alkaline phosphatase, and total bilirubin been obtained before initiating treatment? ☐ Yes ☐ No
   5a. ALT level:_____(U/L)
   5b. AST level:_____(U/L)
   5c. Alkaline phosphatase level:_____(U/L)
   5d. Bilirubin level:_____(mg/dL)
6. For reauthorization:
   6a. During the first year, has the recipient received liver-related tests (ALT and AST, at a minimum) prior to each increase in dose or monthly, whichever occurs first? ☐ Yes ☐ No
   6b. After the first year, has the recipient received these tests at least every 3 months and before any increase in dose? ☐ Yes ☐ No
7. ☐ Failed two preferred drug(s). List preferred drugs failed:_____
   7a. ☐ Allergic Reaction
   7b. ☐ Drug-to-drug interaction. Please describe reaction:_____
8. ☐ Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information:
_____
9. ☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s). Please provide clinical information:_____
10. ☐ Age specific indications. Please give patient age and explain: _____
11. ☐ Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a general reference:
_____
12. ☐ Unacceptable clinical risk associated with therapeutic change. Please explain:_____

Signature of Prescriber:_____ Date:_____

*Prescriber signature mandatory

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (877) 386-4695 Pharmacy PA Call Center: (833) 585-4309