carolina complete health

Pharmacy Request for Prior Approval - Juxtapid

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 member been diagnosed with homozygous familial hypercholesterolemia (HoFH)? ☐ Yes ☐ No
2. Is the member enrolled in the Juxtapid REMS program? ☐ Yes ☐ No
3. Is the member at least 18 years old or older? ☐ Yes ☐ No
4. Is the member 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 member 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 member 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: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/