

OPTIMA HEALTH COMMUNITY CARE

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-319-5003. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete forms will delay the authorization process.

Drug Requested: (Please check applicable drug below)

MEDICAID

Juxtapid® (lomitapide) capsules

Kynamro® (mipomersen sodium) Inj

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Dosage Name/Form: _____

Strength: _____

Quantity per Day: _____

Length of Therapy: _____

Diagnosis: _____

ICD Code, if applicable: _____

CLINICAL CRITERIA: Check applicable box (es) below. If not checked, authorization process will be delayed.

- Does the patient have a diagnosis of homozygous familial hypercholesterolemia (HoFH)? Yes No
- Is the patient at least 18 years of age? Yes No
- Is the prescribing provider certified with the applicable REMS program? Yes No
- Has the patient had a treatment failure, maximum dosing with or contraindication to: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents and bile acid sequestrants? Yes No
- List previous medications (include drug name/dose): _____

****Use of samples to initiate therapy does not meet step-edit/preauthorization criteria. ****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Physician Name: _____

Physician Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____