# OPTIMA HEALTH PLAN

## 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 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

**Drug Requested:** **Juxtapid**® (lomitapide)

***DRUG INFORMATION: Complete information below. Authorization process will be delayed if incomplete.***

**Drug Form/Strength:** ____________________________________________

**Dosing Schedule**: ______________________________ **Length of Therapy**: ____________________

**Diagnosis**: ______________________________ ***ICD Code, if applicable***: ________________

****Medical notes must be submitted to support each line checked on this request.****

***CLINICAL CRITERIA: ALL appropriate boxes must be checked to qualify or authorization process will be delayed.***

- ❑ Patient must be ≥ 18 years old
- ❑ Prescribers must enroll in the Juxtapid™ REMS program, and submit the Prescriber Enrollment Form to the Juxtapid™ REMS program.
- ❑ Patient has tried ***one (1)*** of the following in the ***past 6 months*** and is able to **provide documentation presenting evidence of adherence to statin therapy for at least** the ***last 90 consecutive days***:

| | | |
|---|---|---|
| ❑ Crestor® (rosuvastatin) 40mg/day | ❑ Zocor® (simvastatin) 40mg/day | ❑ Mevacor® (lovastatin) 80mg/day |
| ❑ Lipitor® (atorvastatin) 80mg/day | ❑ Pravachol® (pravastatin) 80mg/day | ❑ Lescol® (fluvastatin) 80mg/day |
| ❑ Livalo® (pitavastatin) 4mg/day | | |

- ❑ Patient has undergone at least one LDL apheresis procedure

*****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: ____________________

Prescriber Name: ____________________________________________

Prescriber Signature: ______________________________ Date: ____________________

Office Contact Name: ____________________________________________

Phone Number: ______________________________ Fax Number: ____________________

**DEA OR NPI #:** ____________________________________________

***Approved by Pharmacy and Therapeutics Committee:** 10/17/2013
**REVISED/UPDATED:** ~~12/27/2013; 4/9/2014; 10/31/2014; 5/21/2015; 12/28/2015; 12/19/2016;~~ **9/21/2017**