

Juxtapid® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below:					
<input type="checkbox"/> Homozygous familial hypercholesterolemia (HoFH)					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical Information:					
Has the prescriber enrolled in the Juxtapid REMS program and Prescriber Enrollment Form has been submitted to the Juxtapid REMS program? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the patient undergone at least one LDL apheresis procedure? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<i>Medical notes must be submitted</i>					
Medication History:					
Select if the patient has tried the following statin therapies in the <u>past 6 months</u> (provide documentation presenting evidence of adherence to statin therapy for at least the <u>last 90 consecutive days</u>):					
<input type="checkbox"/> Crestor (rosuvastatin) 40 mg/day					
<input type="checkbox"/> Lescol (fluvastatin) 80 mg/day					
<input type="checkbox"/> Lipitor (atorvastatin) 80 mg/day					
<input type="checkbox"/> Livalo (pitavastatin) 4 mg/day					
<input type="checkbox"/> Mevacor (lovastatin) 80 mg/day					
<input type="checkbox"/> Pravachol (pravastatin) 80 mg/day					
<input type="checkbox"/> Zocor (simvastatin) 40 mg/day					
<i>Medical notes must be submitted</i>					
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.					
Prescriber Signature: _____			Date: _____		

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
 For urgent or expedited requests please call 1-800-711-4555.
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.