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; **(Pharmacy) 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Juxtapid® (lomitapide)

DRUG INFORMATION: Complete information below or authorization 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: Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation including labs or chart notes (if required) **must** be submitted or request will be denied.

- ❑ 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
  - ❑ Lescol® (fluvastatin) 80mg/day
  - ❑ Lipitor® (atorvastatin) 80mg/day
  - ❑ Livalo® (pitavastatin) 4mg/day
  - ❑ Mevacor® (lovastatin) 80mg/day
  - ❑ Pravachol® (pravastatin) 80mg/day
  - ❑ Zocor® (simvastatin) 40mg/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; 8/14/2017;~~ **(Reformatted) 6/18/2019**