SENTARA COMMUNITY PLAN
(MEDICAID)

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. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Juxtapid® (lomitapide)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Requested Medication is ONE of the following:

- ❑ New Start
- ❑ Continuation of therapy

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Authorization Length: 12 months

Does member meet the following criteria?

1. Does member have a diagnosis of homozygous familial hypercholesterolemia (HoFH)?
   ❑ Yes ❑ No
2. Is member at least 2 years of age?
   ❑ Yes ❑ No

(Continued on next page)

3. If the member is age appropriate, has the member 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
4. 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.

REVISED/UPDATED/REFORMATTED: ~~6/29/2017; 8/31/2017; 8/23/2018; 12/9/2019; 11/7/2023;~~ **10/16/2026**