AvMed

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 1-305-671-0200**. 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 AvMed #: _____ **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:** _____

Recommended Dosage:

- **Adults –** Oral: Initial: 5 mg once daily; after ≥2 weeks of therapy, may increase to 10 mg once daily, as tolerated; then at ≥4-week intervals, may increase to 20 mg once daily, then to 40 mg once daily, and finally to a maximum dose of 60 mg/day as tolerated.
- **Children ≥ 2 years and Adolescents < 18 years –** Oral: Initial dose and titration schedule varies based on age; titrate dose as needed based on patient tolerability, desired low-density lipoprotein cholesterol (LDL-C) levels, and adverse effects. Adjust dose as needed when patient crosses into next age group.

(Continued on next page)

Age Groups	Weeks 0 to 4	Weeks 5 to 8	Weeks 9 to 12	Weeks 13 to 16	Weeks 17 and beyond
2 to < 11 years	2 mg once daily	Continue 2 mg once daily	Increase to 5 mg once daily	Increase to 10 mg once daily	Increase to 20 mg once daily. Max daily dose: 20 mg/day
11 to < 16 years	2 mg once daily	Increase to 5 mg once daily	Increase to 10 mg once daily	Increase to 20 mg once daily	Increase to 40 mg once daily. Max daily dose: 40 mg/day
16 to < 18 years	5 mg once daily	Increase to 10 mg once daily	Increase to 20 mg once daily	Increase to 40 mg once daily	Continue 40 mg once daily. Max daily dose: 40 mg/day

Quantity Limits:

- 2, 5 & 10 mg capsules – 1 capsule per day
- 20 & 30 mg capsules – 2 capsules per day

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.

- ❑ Member must be ≥ 2 years old
- ❑ Prescribers must enroll in the Juxtapid™ REMS program, and submit the Prescriber Enrollment Form to the Juxtapid™ REMS program.
- ❑ Member has tried **one (1)** of the following in the **past 6 months** and is able to **provide documentation demonstrating evidence of adherence to statin therapy for at least the last 90 consecutive days**:
  - ❑ Crestor® (rosuvastatin) 40 mg/day
  - ❑ Lescol® (fluvastatin) 80 mg/day
  - ❑ Lipitor® (atorvastatin) 80 mg/day
  - ❑ Livalo® (pitavastatin) 4 mg/day
  - ❑ Mevacor® (lovastatin) 80 mg/day
  - ❑ Pravachol® (pravastatin) 80 mg/day
  - ❑ Zocor® (simvastatin) 40 mg/day
- ❑ Member has undergone at least one LDL apheresis procedure

Medication being provided by Specialty Pharmacy – Proprium Rx

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****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.****

***Approved by Pharmacy and Therapeutics Committee**: ~~10/17/2013;~~ **5/28/2026**
REVISED/UPDATED/REFORMATTED: ~~8/14/2017; 6/18/2019;~~ **6/15/2026**