Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Juxtapid-Kynamro (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Juxtapid-Kynamro (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Juxtapid (lomitapide) Kynamro (mipomersen)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 5.]

2. Has treatment with the requested drug resulted in at least a 30% reduction in LDL from baseline? Y N

   NOTE: Results of fasting lipid profile within the past 90 days must be submitted with renewal requests. Requests without lab results will not be accepted.

   [If no, then no further questions.]

3. Does the patient have liver function tests (LFT's) that are less than 3 times the upper limit of normal since starting the medication? Y N

   NOTE: Results of LFT's must be submitted with renewal requests. Requests without lab results will not be accepted.

   [If no, then no further questions.]

4. Is the patient compliant with the requested drug as well as with concomitant lipid lowering medications (e.g., statins, ezetimibe, bile acid sequestrant)? Y N

   NOTE: Pharmacy claim history will be reviewed to confirm refills.

   [No further questions]

5. Does the patient have a diagnosis of homozygous familial hypercholesterolemia (HoFH)? Y N

   [If no, then no further questions.]

6. Does the patient have genetic confirmation of 2 mutant alleles at LDLR, APO-B100, or PCSK9? Y N

   NOTE: Medical records to support diagnosis must be submitted with request. Requests without records will not be accepted.

   [If yes, skip to question 9.]

7. Does the patient have a history of a treated LDL-C greater than 300mg/dL on maximum dosed statin OR an untreated LDL-C greater than 500mg/dL at any time? Y N

   NOTE: Results of fasting lipid profile must be submitted with request. Requests without lab results will not be accepted.

   [If no, then no further questions.]

8. Do BOTH of the patient's parents have HeFH (LDL greater than or equal to 190 mg/dL) OR did the patient have cutaneous xanthoma(s) present before the age of 10? Y N

   NOTE: Medical records to support diagnosis must be submitted with request. Requests without records will not be accepted.

   [If no, then no further questions.]

9. Is the patient unable to tolerate statins? Y N

NOTE: Medical records must be submitted supporting that skeletal muscle related symptoms (e.g., myopathy, myositis or abnormal biomarkers) occurred while taking 2 different statins for more than 2 weeks (at least one being a moderate to high potency statin) and the symptoms resolved when statin therapy was discontinued and that the patient has been rechallenged with at least 2 different statins at an equivalent or lower dose.

[If yes, skip to question 11.]

10. Has the patient failed an adequate 90 day trial of 2 high intensity statins (e.g., atorvastatin 40 mg or greater and rosuvastatin 20 mg or greater) at maximum tolerated doses and in combination with other lipid lowering therapies such as ezetimibe or bile acid sequestrants? Y N

    NOTE: Pharmacy claim history will be reviewed to confirm refills.

    Please document medication regimens tried and reason for treatment failure: _____

    [If no, then no further questions.]

11. Will the requested drug be used as an adjunct to lipid lowering therapies such as statins, ezetimibe, or a bile acid sequestrant? Y N

    Please document which treatment(s) will be used:
    _____

    [If yes, skip to question 14.]

12. Is the request for Juxtapid? Y N

    [If no, then no further questions.]

13. Will the requested drug be used as an adjunct to LDL apheresis? Y N

    [If no, then no further questions.]

14. Has the patient failed a 90 day trial of or experienced intolerable side effects with Repatha? Y N

    Please describe treatment failure or intolerance experienced:
    _____

    [If no, then no further questions.]

15. Will the requested drug be used with a PCSK9 inhibitor? Y N

    [If yes, then no further questions.]

16. Is the requested drug prescribed by, or in consultation with, a cardiologist, endocrinologist, or lipid specialist? Y N

    [If no, then no further questions.]

17. Is the patient at least 18 years of age? Y N

    [If no, then no further questions.]

18. Is the request for Juxtapid? Y N

    [If no, skip to question 21.]

19. Is the patient pregnant? Y N

    [If yes, then no further questions.]

20. Will Juxtapid be used concomitantly with moderate or strong CYP3A4 inhibitors? Y N

    [No further questions.]

21. Will the patient be receiving adjunctive therapy with LDL apheresis? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date