Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: ______________________________ Strength: _______________ Directions: _______________________________________

Physician Name: ___________________________ Physician Phone #: _________________________ Specialty: ______________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

Horizon NJ Health

Juxtapid (Lomitapide) – Medical Necessity Request

Complete pages 1 and 2 for Initial request and page 3 for Subsequent request

General Questions:

1. **Contraindication Information**
   a. Is the member pregnant? **Yes** or **No**
   b. Is the medication administered concomitantly with moderate or strong CYP3A4 inhibitors? **Yes or No**
   c. Does the member have moderate or severe hepatic impairment (based on Child-Pugh category B or C)? **Yes or No**
   d. Does the member have active liver disease, including unexplained persistent elevations of serum transaminases? **Yes or No**
2. Is medication being prescribed by or in consultation with, a cardiologist, lipid specialist or endocrinologist? **Yes or No**
3. Will the member be receiving another PCSK-9 inhibitor for the same indication? **Yes** or **No**
4. Will the member be on concurrent treatment with another lipid lowering therapy (e.g. statin, fibrate, nicotinic acid, ezetimibe, LDL-apheresis)?**Yes** or **No**
   If Yes, please provide the drug name(s). ____
   If No, why not? ____

Diagnosis Information (please indicate diagnosis and answer related questions):

□ **Homozygous familial hypercholesterolemia (HoFH)**

a. Does member have confirmation of two mutant alleles at the LDLR, Apo-B, PCSK9, ARH adaptor protein 1ocus? **Yes or No**

b. Does member have skin fibroblast LDL receptor activity < 20% normal? **Yes or No**

c. What is member's untreated LDL-C level (mg/dL)? ______________Date taken:

d. What is member's treated LDL-C level (mg/dL)? ______________¬¬¬Date taken:

e. Did member have Cutaneous or tendon xanthoma before age of 10 years? **Yes or No**

f. Does member have history of heterozygous Familial Hypercholesterolemia in both parents? **Yes or No**

g. What is the member’s total cholesterol (TC) in mg/dl? _____________Date taken:

h. What is the member’s non-high density lipoprotein cholesterol (non HDL-C) mg/dl? ______________Date taken:

Physician office's signature*_________________________________ Print Name________________________________

***Form must be completed and signed by physician or licensed representative from the physician’s office**

Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: _____________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

Complete this page for Subsequent Request

General Questions:

1. Will the member be receiving another PCSK-9 inhibitor for the same indication? **Yes** or **No**

2. Is medication being prescribed by or in consultation with, a cardiologist, lipid specialist or endocrinologist? **Yes or No**

3. Will the the member's liver enzymes (i.e. ALT, AST) be monitored? **Yes or No**

4. Will the member continue to receive the requested drug together with other lipid-lowering therapy (e.g. statin, ezetimibe, LDL apheresis)? **Yes or No**
   - □ **Yes**, please provide drug name(s)____
   - □ **No** –Why not?:____

5. Please provide the LDL-C, total cholesterol (TC), and/or non-high density lipoprotein-cholesterol (non HDL-C) while on therapy and date taken.

   LDL: Level: _____________mg/dL Date Taken: ______________

   TC: Level: _____________mg/dL Date Taken: ______________

   Non HDL-C: Level: _____________mg/dL Date Taken: ______________

Physician office's signature*________________________________ Print Name_______________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**