AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Juxtapid

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other:_____

Clinical Information

1. Has the beneficiary been diagnosed with homozygous familial hypercholesterolemia (HoFH)? Yes___ No___
2. Is the beneficiary enrolled in the Juxtapid REMS program? Yes___ No___
3. Is the beneficiary at least 18 years old or older? Yes___ No___
4. Is the beneficiary female? Yes___ No___ (if Yes, then answer 4a; if No, then move to question 5)
   4a. If female, has a negative pregnancy test been obtained? Yes___ No___
5. Has a measurement of the beneficiary's ALT, AST, alkaline phosphatase, and total bilirubin been obtained before initiating treatment? Yes___ No___
   5a. ALT level: _____ (U/L)
   5b. AST level: _____ (U/L)
   5c. Alkaline phosphatase level: _____ (U/L)
   5d. Bilirubin level: _____ (mg/dL)
6. For reauthorization:
   6a. During the first year, has the beneficiary received liver-related tests (ALT and AST, at a minimum) prior to each increase in dose or monthly, whichever occurs first? Yes___ No___
   6b. After the first year, has the beneficiary received these tests at least every 3 months and before any increase in dose? Yes___ No___
7. Failed two preferred drugs. List preferred drugs failed: _____
   7a. Allergic reaction: _____
   7b. Drug-to-drug interaction. Please describe reaction: _____
8. Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information: _____
_____
9. Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s). Please provide clinical information: _____
10. Age specific indications. Please give patient age and explain: _____
11. Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a general reference: _____
12. Unacceptable clinical risk associated with therapeutic change. Please explain: _____
_____

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406