Health Partners Plans

# HEALTH PARTNERS MEDICARE
## *PRIOR AUTHORIZATION REQUEST FORM*

Juxtapid - Medicare

**Phone: 215-991-4300** **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

| **Patient Name:** | **Prescriber Name:** | |
|---|---|---|
| Member Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| Line of Business: □ Medicare | NPI: | State Lic ID: |
| Address: | Address: | |
| City, State ZIP: | City, State ZIP: | |
| Primary Phone: | Specialty/facility name (if applicable): | |

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:
Strength:
Directions / SIG:

**Please attach any pertinent medical history including labs and information for this member that may support approval.**
**Please answer the following questions and sign.**

Q1. Is Juxtapid being prescribed by or in consultation with an endocrinologist or cardiologist?
☐ Yes ☐ No

Q2. Is the physician enrolled in the Juxtapid Risk Evaluation and Mitigation Strategies (REMS) program?
☐ Yes ☐ No

Q3. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q4. Does the patient have a confirmed diagnosis of homozygous familial hypercholesterolemia? Please submit genetic testing.
☐ Yes ☐ No

Q5. Is the patient a male or a nonreproductive female?
☐ Yes ☐ No

Q6. Does the patient have a negative pregnancy test and will pregnancy status be monitored throughout the course of treatment?
☐ Yes ☐ No

Q7. Does the patient have moderate or severe hepatic impairment (based on Child-Pugh category B or C) or active liver disease including unexplained persistent elevations of serum transaminases?
☐ Yes ☐ No

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|---|---|

Q8. Will Juxtapid be used in combination with moderate or strong cytochrome P3A4 (CYP3A4) inhibitors and/or Kynamro?

☐ Yes ☐ No

Q9. Has a post-treatment (if applicable) liver function test and lipid profile been submitted for review and will levels be monitored throughout the course of treatment?

☐ Yes ☐ No

Q10. Is this a request for a continuation of therapy?

☐ Yes ☐ No

Q11. Has the patient had previous treatment with inadequate response, intolerance, or contraindication to standard lipid-lowering regimen containing high potency statins (atorvatstatin 40 mg or 80 mg OR rosuvastatin 20 mg or 40 mg)? Please attach documentation with explanation of intolerance or contraindication.

☐ Yes ☐ No

Q12. Has the patient had previous treatment with inadequate response, intolerance, or contraindication to utilizing a PCSK9 inhibitor (Repatha) to manage the condition?
Please attach documentation with explanation of intolerance or contraindication.

☐ Yes ☐ No

Q13. Will Juxtapid be used in combination with other lipid-lowering treatments such as statins, fenofibrates, ezetimibe, or niacin?

☐ Yes ☐ No

Q14. Additional Information:

Q15. Requested Duration:

☐ 6 months

Prescriber Signature

Date

2021 Medicare Prior Authorization Request