



NC DMA Pharmacy Request for Prior Approval - Juxtapid IM



Recipient Information

DMA-0101 (V.01)

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

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: Health Choice:

Prescriber Information

7. Prescribing Provider #: _____ NPI: or Atypical:
 8. Prescriber DEA #: _____
 Requester Contact Information
 Name: _____ Phone #: _____ Ext: _____

Drug Information

9. Drug Name: _____ 10. Strength: _____ 11. Quantity Per 30 Days: _____
 12. Length of Therapy (in days): up to 30 60 90 120 180 365 Other: _____

Clinical Information

Request for Non-Preferred Drug:

1. Has the recipient been diagnosed with homozygous familial hypercholesterolemia (HoFH)? Yes No
 2. Is the recipient enrolled in the Juxtapid or Kynamro REMS program? Yes No
 3. Is the recipient at least 18 years old or older? Yes No
 4. Is the recipient 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 recipient'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 recipient 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 recipient received these tests at least every 3 months and before any increase in dose? Yes No
 7. Failed two preferred drug(s). 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 CSRA at: (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505