



NC DHB Pharmacy Request for Prior Approval - Juxtapid or Kynamro

Recipient Information

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: _____

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: (800) 678-3189

Pharmacy PA Call Center: (866) 799-5318