Trillium Health Resources
Pharmacy Prior Approval Request for

Juxtapid

Member Information

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

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: **Juxtapid** 2. Strength: _____ 3. Quantity Per 30 Days: _____
4. Length of Therapy (**in Days**): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

1. Has the recipient been diagnosed with homozygous familial hypercholesterolemia (HoFH)? ☐ **Yes** ☐ **No**
2. Is the recipient enrolled in the Juxtapid 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)
   a. 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**
   a. ALT level: _____ (U/L)
   b. AST level: _____ (U/L)
   c. Alkaline phosphatase level: _____ (U/L)
   d. Bilirubin level: _____ (mg/dL)
6. **For reauthorization**:
   a. 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**
   b. 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: _____**and/or**
   a. ☐ Allergic Reaction **and/or**
   b. ☐ Drug-to-drug interaction. Please describe reaction(s):_____
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 PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277