



**New Hampshire Medicaid Fee-for-Service Program  
Prior Authorization Drug Approval Form**

Juxtapid® (lomitapide)

DATE OF MEDICATION REQUEST:    /    /

**SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED**

LAST NAME:

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FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MEDICAID ID NUMBER:

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DATE OF BIRTH:

				-					-				
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GENDER:  Male  Female

Drug Name

Strength

Dosing Directions

Length of Therapy

**SECTION II: PRESCRIBER INFORMATION**

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

				-					-				
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FAX NUMBER:

				-					-				
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**SECTION III: CLINICAL HISTORY**

1. Please list the diagnosis for which this medication is being requested and confirmation test, if applicable:

2. Is the prescriber a cardiologist, lipidologist, or endocrinologist or has one of these specialists  Yes  No been consulted?

3. Has the patient tried and failed maximum tolerated doses of atorvastatin or rosuvastatin and  Yes  No one other cholesterol medication?

a. If yes, please list medication, dose not tolerated, and length of treatment:

*(Form continued on the next page.)*



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Juxtapid® (lomitapide)

DATE OF MEDICATION REQUEST:     /     /

**PATIENT LAST NAME:**

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**PATIENT FIRST NAME:**

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**SECTION III: CLINICAL HISTORY (CONTINUED)**

4. Is the patient enrolled in the Juxtapid REMS program?  Yes  No

5. Please list lipid panel results:

6. For renewal after initial 6-month request, please list recent lipid panel results:

**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.**

**PRESCRIBER'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_