Reset Form Print Form

# 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:** **FIRST NAME:**

**MEDICAID ID NUMBER:** **DATE OF BIRTH:** – –

**GENDER:** ☐ Male ☐ Female

**Drug Name** **Strength**

**Dosing Directions** **Length of Therapy**

## SECTION II: PRESCRIBER INFORMATION

**LAST NAME:** **FIRST NAME:**

**SPECIALTY:** **NPI NUMBER:**

**PHONE NUMBER:** – – **FAX NUMBER:** – – –

## 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 been consulted? ☐ Yes ☐ No

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

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

*(Form continued on the next page.)*

**Phone**: 1-866-675-7755 **Fax**: 1-888-603-7696

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Effective Date: 12/04/2024

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**Prior Authorization Drug Approval Form**

Juxtapid® (lomitapide)

**DATE OF MEDICATION REQUEST: / /**

**PATIENT LAST NAME:**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |

**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**: _____

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Prime THERAPEUTICS™