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

Effective Date: 12/04/2024

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DATE OF MEDICATION REQUEST: / /

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

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™