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United Healthcare Community Plan

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

JUXTAPID™ (LOMITAPIDE)

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

JUXTAPID™ – to receive approval for this drug, complete the following questions:

Does the member meet the following criteria?

1. Does the member have a diagnosis of homozygous familial hypercholesterolemia (HoFH)?
   ☐ Yes ☐ No
2. Is the member at least 18 years of age?
   ☐ Yes ☐ No
3. Is the prescribing provider certified with the applicable REMS program?
   ☐ Yes ☐ No
4. Has the member had a treatment failure, maximum dosing with, or contraindication to: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, and bile acid sequestrants?
   ☐ Yes ☐ No
5. List previous medications (include drug name/dose):

   _____

   _____

   _____

   _____

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328

Pharmacy PA call center: 1-800-310-6826