# TEXAS MEDICAID
# Clinical Edit Prior Authorization
# lomitapide (JUXTAPID)

| STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING | |
|---|---|
| Date: | Prescriber First & Last Name: |
| Patient First & Last Name: | Prescriber NPI: |
| Patient Address: | Prescriber Address: |
| Patient ID: | Prescriber Phone: |
| Patient Date of Birth: | Prescriber Fax: |

| STEP 2: MEDICATION INFORMATION | |
|---|---|
| Medication Requested (Name): | Quantity Requested: |
| Dose Requested: | Dosing Instructions: |

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Indicate the drug's formulary status: *(Formulary available at www.txvendordrug.com)

☐ Non-Preferred Drug **(NPD or NAP Status, Go to Step 3 - PDL PA Criteria Applies)**

**OR** ☐ Preferred Drug **(Go to Step 4)**

**OR** ☐ No Status, Drug is not in a Market Basket **(Go to Step 4)**

**OR** ☐ N/A as this request is for a CHIP / PERINATE client **(Go to Step 4)**

## STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the last 180 days?

   ☐ Yes (Go to Step 4, Question 1) ☐ No (Go to #2)

2. Is there a documented allergy or contraindication to preferred agents in this class?

   ☐ Yes (Go to Step 4, Question 1) ☐ No (Go to #3)

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3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

☐ Yes (Go to Step 4, Question 1) ☐ No (Deny)

**STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA**

1. Is the client greater than or equal to (≥) 18 years of age?

☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client have a diagnosis of homozygous familial hypercholesterolemia (HoFH) in the last 730 days?

☐ Yes (Go to #3) ☐ No (Deny)

3. Is the client currently pregnant?

☐ Yes (Deny) ☐ No (Go to #4)

4. Does the client have a claim for a strong or moderate CYP3A4 inhibitor in the last 90 days?

☐ Yes (Deny) ☐ No (Go to #5)

5. Does the client have a diagnosis of moderate or severe hepatic impairment in the last 365 days?

☐ Yes (Deny) ☐ No (Go to #6)

6. Does the client have at least one claim for lomitapide (JUXTAPID) in the last 90 days?

☐ Yes (Go to #7) ☐ No (Go to #8)

7. Has the client shown clinical response (significant lowering of low-density lipoprotein cholesterol (LDL-C)*) since initiation of lomitapide (JUXTAPID) therapy? [Manual Step]

☐ Yes (Go to #10) ☐ No (Deny)

*Significant lowering of LDL-C is defined as a 30% decrease in LDL for patients with a diagnosis of homozygous familial hypercholesterolemia.

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8. Has the client had at least 90 consecutive days of high dose atorvastatin therapy, 90 consecutive days of high dose rosuvastatin therapy, and 90 consecutive days of ezetimibe (ZETIA) therapy in the last 730 days?

   Examples of high dose statin therapy include 40mg to 80mg doses of atorvastatin (LIPITOR) and 20mg to 40mg of rosuvastatin (CRESTOR, EZALLOR SPRINKLE).

   ☐ Yes (Go to #9) ☐ No (Deny)

9. Does the client have a documented low-density lipoprotein cholesterol (LDL-C) of greater than (>) 70mg/dL? [Manual Step]

   ☐ Yes (Go to #10) ☐ No (Deny)

10. Is the requested dose less than or equal to (≤) 2 capsules daily?

    ☐ Yes (Approve – 365 days) ☐ No (Deny)

**STEP 5: SIGN AND FAX TO:** NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

**Prescriber Signature:** _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.

For questions, please call Navitus Customer Care at 1-877-908-6023.