



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit go.covermymeds.com/OptumRx to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Juxtapid[®] Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)				Provider Information (required)			
Member Name:				Provider Name:			
Insurance ID#:				NPI#:		Specialty:	
Date of Birth:				Office Phone:			
Street Address:				Office Fax:			
City:		State:		Zip:		Office Street Address:	
Phone:				City:		State:	
Zip:				Zip:			
Medication Information (required)							
Medication Name:				Strength:		Dosage Form:	
<input type="checkbox"/> Check if requesting brand				Directions for Use:			
<input type="checkbox"/> Check if request is for continuation of therapy							
Clinical Information (required)							
Select the diagnosis below: <input type="checkbox"/> Homozygous familial hypercholesterolemia (HoFH) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____							
Clinical Information: Select if medical records (e.g., chart notes, laboratory values) will be submitted documenting the patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) as confirmed by the following:* <input type="checkbox"/> Genetic confirmation of 2 mutations in the LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1 (i.e., LDLRAP1 or ARH) <input type="checkbox"/> Untreated LDL-C greater than 500mg/dL or treated LDL-C greater than 300 mg/dL <input type="checkbox"/> Xanthoma before 10 years of age <input type="checkbox"/> Evidence of heterozygous familial hypercholesterolemia (HeFH) in both parents <i>*Please note: Chart documentation of the above is required to be submitted along with this fax.</i> Is the patient receiving other lipid-lowering therapy (e.g., statin, ezetimibe)? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had trial and failure, contraindication, or intolerance to Repatha therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Will Juxtapid be used as adjunct to a low-fat diet and exercise regimen? <input type="checkbox"/> Yes <input type="checkbox"/> No Select the prescriber's specialty: <input type="checkbox"/> Cardiologist <input type="checkbox"/> Endocrinologist <input type="checkbox"/> Lipid specialist Will Juxtapid be used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Reauthorization: If this is a reauthorization request, answer the following questions: Does the patient continue to receive other lipid-lowering therapy (e.g., statin, ezetimibe)? <input type="checkbox"/> Yes <input type="checkbox"/> No Will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has had LDL-C reduction while on Juxtapid therapy?* <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please note: Chart documentation of the above is required to be submitted along with this fax.</i> Is the patient continuing a low-fat diet and exercise regimen? <input type="checkbox"/> Yes <input type="checkbox"/> No Select the prescriber's specialty: <input type="checkbox"/> Cardiologist <input type="checkbox"/> Endocrinologist <input type="checkbox"/> Lipid specialist Will Juxtapid be used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor? <input type="checkbox"/> Yes <input type="checkbox"/> No							

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Juxtapid_Comm_2019Mar-W



Juxtapid[®] Prior Authorization Request Form (Page 2 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Quantity Limit Requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- Titration or loading dose purposes
- Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- Requested strength/dose is not commercially available
- Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note:

This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.