



**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:

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FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER: Male Female

Drug Name

Strength

Dosing Directions

Length of Therapy

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

				-					-				
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FAX NUMBER:

				-					-				
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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 Yes No
been consulted?

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

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

(Form continued on the next page.)



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DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

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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:** _____