UPMC Health Plan

JUXTAPID, KYNAMRO

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, please call UPMC Health Plan Pharmacy Services.
Otherwise, please return completed form to:
UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-396-4139 FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY. ***Incomplete responses may delay this request.***

Office Contact:		**Provider Specialty:**	
Provider First Name:		**Provider Last Name:**	
Provider Phone:		**Provider Fax:**	**Provider NPI #:**
Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient DOB:**	**Patient Age:**
Drug Requested: ☐ **Brand** ☐ **Generic**	**Strength:**	**Frequency:**	**Qty. Dispensed:**

Generic equivalent drugs will be substituted for brand-name drugs unless you specifically indicate otherwise.

☐ **New medication** ☐ **Ongoing medication**	**If ongoing, provide date started:**	**If medication is ongoing, did member show improvement while on therapy?**	☐ **Yes** ☐ **No**

Diagnosis:

MEDICAL HISTORY

Is the provider a clinical lipidologist?	☐ **Yes** ☐ **No**
If no, was a clinical lipidologist consulted on the diagnosis and prescribing of the requested medication?	☐ **Yes** ☐ **No**
Does the member have a diagnosis of Homozygous Familial Hypercholesterolemia? ❖ Please provide chart documentation of the diagnosis, including how the diagnosis was made, rule out diagnoses, and any diagnostic testing or laboratory assessments completed.	☐ **Yes** ☐ **No**

Please indicate if the member has any of the following:

- ☐ Functional mutation(s) in both LDL receptor alleles or alleles known to affect LDL receptor functionality
  If so, please provide chart documentation of the diagnostic test.
- ☐ Skin fibroblast LDL receptor activity less than 20% of normal
- ☐ Presence of cutaneous and tendon xanthomas and corneal arcus
  If so, please provide age of onset: _____
- ☐ Both parents with documented history of untreated total cholesterol greater than 250mg/dL

Female members (Juxtapid requests only)	**If the member is of childbearing potential, has she had a baseline (within 1 month) negative pregnancy test prior to initiation of therapy?** Please provide date of test: _____	☐ **Yes** ☐ **No** ☐ **Not applicable**
	If the member is of childbearing potential, is she currently using a medically acceptable method of contraception?	☐ **Yes** ☐ **No** ☐ **Not applicable**
Did the member have baseline (within 1 month) transaminase, alkaline phosphatase, and bilirubin levels tested? Please provide date of test: _____		☐ **Yes** ☐ **No**
Did the member have baseline (within 1 month) cholesterol levels tested? Please provide date of test: _____ Please provide baseline levels: ☐ Total cholesterol: _____ ☐ LDL cholesterol: _____ ☐ Triglycerides: _____		☐ **Yes** ☐ **No**

Please be sure to complete and include the 2nd page of this form.

KYNAMRO, JUXTAPID

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Patient Name	Patient UPMC Health Plan ID Number	Patient DOB

Please be sure to complete and include this page with the 1st page of this form

Does the member have moderate to severe hepatic impairment?	☐ **Yes** ☐ **No**
Is the member on concomitant therapy with any moderate or strong inhibitors of CYP3A4 (such as amprenavir, aprepitant, atazanavir, ciprofloxacin, crizotinib, darunavir/ritonavir, diltiazem, erythromycin, fluconazole, fosamprenavir, imatinib, verapamil, boceprevir, clarithromycin, conivaptan, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, mibefradil, nefazodone, nelfinavir, posaconazole, ritonavir, saquinavir, telaprevir, telithromycin, voriconazole)?	☐ **Yes** ☐ **No**

Please list all medications the member has previously tried and failed or is currently using.

Medication Name	Strength	Frequency	Dates of Trial		List adverse reactions/side effects/reason for discontinuation
			Start Date	End Date	

Is this request for a reauthorization? ☐ **Yes** ☐ **No**

If yes, please provide the following documentation:

- ☐ Documentation showing member's disease has stabilized
- ☐ Documentation showing member's transaminase, alkaline phosphatase, and bilirubin levels are being monitored regularly. Please provide dates of all tests completed: _____
- ☐ Documentation of reduction in LDL level since starting treatment
  - LDL levels: _____
  - Dates of all tests completed: _____

Please provide any additional information that should be considered in the space below: