Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Juxtapid
(lomitapide mesylate)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested: ☐ Juxtapid ICD10:

Dose: Directions for use: Duration of therapy:

Is this a new start or continued therapy? ☐ new start ☐ continued therapy
(if continued therapy) Is there documented evidence of clinical beneficial response (for example, demonstrated reduction of LDL-C)? Please provide this documentation.

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:
☐ homozygous familial hypercholesterolemia (HoFH) ☐ Other *(please specify):*

Clinical Information
****This drug requires supportive documentation (i.e. genetic testing, chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.****

Does your patient have genetic confirmation of 2 mutant alleles at the LDL receptor, ApoB, PCSK9 or ARH adaptor protein gene locus)? Yes ☐ No ☐

(if no) Does your patient have a history of either of the following? Yes ☐ No ☐
- ☐ an untreated LDL-cholesterol concentration greater than 500 mg/dL
- ☐ a total treated LDL-C greater than or equal to 300 mg/dL
- ☐ neither of the above

(if no) Which of the following apply to your patient?
- ☐ clinical manifestations of HoFH (for example, cutaneous xanthomas before the age of 10 years, tendon xanthomas)
- ☐ untreated LDL cholesterol levels greater than 190mg/dl in both parents
- ☐ neither of the above

Has your patient been previously treated with maximally tolerated lipid lowering therapy regimen (for example, high-intensity statins like atorvastatin/Lipitor, rosuvastatin/Crestor, ezetimibe/Zetia, LDL apheresis where available)? Yes ☐ No ☐

If yes, please provide the following: drug names, doses, dates of therapy, and results of each therapy. If no, please explain any contraindications to currently available therapies.

While on these medications, did your patient have either of the following responses to this therapy? Please provide labs.
- ☐ LDL-C greater than 100 mg/dL
- ☐ LDL-C level of 71-99 mg/dL AND your patient also has ASCVD (atherosclerotic cardiovascular disease)
- ☐ neither of the above

(if not previously tried max tolerated lipid lowering therapy regimen) Is your patient able to try maximally tolerated lipid lowering therapy regimen (for example, high-intensity statin, ezetimibe/Zetia, or LDL apheresis where available)? Yes ☐ No ☐
(if not able to try) Please list all contraindication(s) that your patient has to using maximally tolerated lipid lowering therapy regimens.
_____

Has your patient been previously treated with Repatha? Yes ☐ No ☐
(if no) Does your patient have a contraindication per FDA label, an inability to use, or is not a candidate for to Repatha? Yes ☐ No ☐

(if yes) Please provide the following for Repatha: dose, dates of therapy, and results of therapy.

While on Repatha, did your patient have either of the following responses to this therapy? Please provide labs.
☐ LDL-C greater than 100 mg/dL
☐ LDL-C level of 71-99 mg/dL AND your patient also has ASCVD (atherosclerotic cardiovascular disease)
☐ neither of the above
(if neither) Does your patient have a documented intolerance to Repatha? Yes ☐ No ☐

In addition to Juxtapid, will/is your patient also being treated with a maximally tolerated lipid lowering regimen? Yes ☐ No ☐
(if yes) Please provide the drug names, strengths, and dosing schedules.

In addition to Juxtapid, will/is your patient following a low-fat diet? (patient verbal confirmation of this is sufficient) Yes ☐ No ☐
Will your patient also be treated with a PCSK9 monoclonal antibody (for example, Praluent or Repatha)? Yes ☐ No ☐

Does your patient have any of the following: moderate or severe hepatic impairment (based on Child-Pugh category B or C), active liver disease, or unexplained persistent abnormal liver function tests? Yes ☐ No ☐

This drug requires supportive documentation (i.e. genetic testing, chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.

Additional pertinent information: (please include clinical reasons for drug, relevant lab values, etc.)

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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