UnitedHealthcare Community Plan

NC Pharmacy Prior Approval Request for

Juxtapid/Kynamro

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. ____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

1. Has the recipient been diagnosed with homozygous familial hypercholesterolemia (HoFH)? ☐ **Yes** ☐ **No**
2. Is the recipient enrolled in the Juxtapid or Kynamro REMS program? ☐ **Yes** ☐ **No**
3. Is the recipient at least 18 years old or older? ☐ **Yes** ☐ **No**
4. Is the recipient female? ☐ **Yes** ☐ **No** (if Yes, then answer 4a; if No then move to question 5)
   4a. If female, has a negative pregnancy test been obtained? ☐ **Yes** ☐ **No**
5. Has a measurement of the recipient's ALT, AST, alkaline phosphatase, and total bilirubin been obtained before initiating treatment? ☐ **Yes** ☐ **No**
   5a. ALT level: _____ (U/L)
   5b. AST level: _____ (U/L)
   5c. Alkaline phosphatase level: _____ (U/L)
   5d. Bilirubin level: _____ (mg/dL)
6. For reauthorization:
   6a. During the first year, has the recipient received liver-related tests (ALT and AST, at a minimum) prior to each increase in dose or monthly, whichever occurs first? ☐ **Yes** ☐ **No**
   6b. After the first year, has the recipient received these tests at least every 3 months and before any increase in dose? ☐ **Yes** ☐ **No**
7. Failed two preferred drug(s). List preferred drugs failed: _____
   7a. Allergic Reaction: _____
   7b. Drug-to-drug interaction. Please describe reaction: _____
8. Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information: _____
9. Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s). Please provide Clinical information: _____
10. Age specific indications. Please give patient age and explain: _____
11. Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a general reference: _____
12. Unacceptable clinical risk associated with therapeutic change. Please explain: _____

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

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.

Fax this form to 1-866-940-7328 Pharmacy PA Call Center: 1-855-258-1593