



Juxtapid® Prior Authorization Request Form

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:
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"/> Heterozygous familial hypercholesterolemia (HeFH)					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical information:					
Is the patient's baseline LDL-C level greater than or equal to 190 mg/dL? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the requested medication prescribed by or in consultation with a cardiologist or endocrinologist? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the patient had trial and failure of Praluent or Repatha? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, what was the documented failure with Praluent or Repatha _____					
What is the medical rationale for use of Juxtapid over Praluent or Repatha? _____					

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 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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