

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

**MEMBER INFORMATION**

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Last Name:

First Name:

Medicaid ID Number:

Date of Birth:

Weight in Kilograms: \_\_\_\_\_

**PRESCRIBER INFORMATION**

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Last Name:

First Name:

NPI Number:

Phone Number:

Fax Number:

**DRUG INFORMATION**

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Drug Name/Form: \_\_\_\_\_

Strength: \_\_\_\_\_

Dosing Frequency: \_\_\_\_\_

Length of Therapy: \_\_\_\_\_

Quantity per Day: \_\_\_\_\_

*(Form continued on next page.)*

Member's Last Name:

Member's First Name:

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**DIAGNOSIS AND MEDICAL INFORMATION**

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**JUXTAPID™ – to receive approval for this drug, complete the following questions:**

Does the member meet the following criteria?

1. Does the member have a diagnosis of homozygous familial hypercholesterolemia (HoFH)?  
 Yes     No
2. Is the member at least 18 years of age?  
 Yes     No
3. Has the member had a treatment failure, maximum dosing with, or contraindication to: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, and bile acid sequestrants?  
 Yes     No
4. List previous medications (include drug name/dose):

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**Prescriber Signature (Required)**

**Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; incomplete forms will delay the SA process. Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center 1-800-310-6826

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