

Physician Request Form for Juxtapid/Kynamro



Fax to Pharmacy Services at 855-811-9332, or call 888-602-3741 to speak to a representative. Form must be completed for processing.

Patient Name: Address: City: State: Phone #: Birth Date:

Patient ID #: Apt # or Suite #: Zip Code:

Physician Name: Address: City: State: Contact Person: Phone #: Prescriber Specialty:

NPI #: Apt # or Suite #: Zip Code: Fax #:

Requested Regimen, Dose, and Duration:

Initial Authorization Request

- Provide patient's complete medical history/co-morbidities:
Patient has a confirmed diagnosis of familial hypercholesterolemia (FH).
Please provide chart notes or clinical labs including three of the following...
Documentation has been provided that the patient has tried and failed consistent therapy with the all three medications...
Is the patient statin intolerant?
Documentation was submitted including an attestation that the patient is following a "heart healthy" diet.
Is this request for Juxtapid?
Is this request for Kynamro?

Reauthorization Request

- Documentation has been submitted indicating that the member has obtained clinical benefit from the medication (check all that apply, labwork must be submitted with request within 60 days of request):
 - Repeat fasting lipid panel lab report

Rationale and/or additional information which may be relevant to the review of this prior authorization request: __

Prescriber Signature: _____ **Date:** _____