NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

WellCare
Beyond Healthcare. A Better You.

NC DHB Pharmacy Request for Prior Approval
Juxtapid or Kynamro

Recipient Information

1. Recipient Last Name:_____2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____5. Recipient Gender:_____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Prescriber Information

7. Prescribing Provider #:_____ NPI: ☐ *or* Atypical: ☐
8. Prescriber DEA #: _____
Requester Contact Information
Name:_____ Phone #:_____Ext:_____

Drug Information

9. Drug Name:_____ 10. Strength: _____11. Quantity Per 30 Days:_____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐Other:_____

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? (if Yes, then answer 4a) **YES**_____**NO**_____
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)

For reauthorization:

6.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**____
6a. 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: **YES__NO____**

7b. Drug-to-drug interaction. Please describe reaction:_____

8. Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information: **YES__NO_**

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: (**800) 678-3189** Pharmacy PA Call Center: (**866) 799-5318**