

Ticket #: _____ Request Date: _____ Request Time: _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of **Juxtapid® lomitapide**. Based on recent clinical information, we require more information before this prescription can be paid by the patient's pharmacy benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information			
Patient Name:		Plan Name/Plan ID:	
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:	
B. Physician Information			
Physician Name:		Physician Address:	
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:
C. Pharmacy Information			
Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:
D. Clinical Information (Please fill out the following information: circle all that apply)			
1. Does patient have homozygous familial hypercholesterolemia (HoFH)?		YES	NO
2. Was baseline ALT, AST, alkaline phosphatase, and total bilirubin been taken at baseline? If this is for a Re-Authorization , please provide same lab results during the first year, measure liver-related tests (ALT and AST, at a minimum) prior to each increase in dose or monthly, whichever occurs first. After the first year, do these tests at least every 3 months and before any increase in dose.		YES	NO
3. Please send copy of LFT or document dates and values below.	_____ _____ _____ _____		
4. Has pregnancy test been performed in females of reproductive potential with a negative result prior to initiation?		YES	NO N/A
Authorized Medical Signature:			
Telephone:		Date:	

When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.

Prior authorization forms are reviewed at least annually and are available at www.procarerx.com. Medical Review Criteria are reviewed at least annually. Revised 09/2015