COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

JUXTAPID™ (LOMITAPIDE) OR KYNAMRO™ (MIPOMERSEN)

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

Please use one form per member.

PATIENT INFORMATION

Last Name: | | | | | | | | | | | | |

First Name: | | | | | | | | | | | | |

Medicaid ID Number: | | | | | | | | | | | | |

Date of Birth: | | | – | | | – | | | | |

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: | | | | | | | | | | | | |

First Name: | | | | | | | | | | | | |

NPI Number: | | | | | | | | | | |

Phone Number: | | | – | | | | – | | | | |

Fax Number: | | | – | | | | – | | | | |

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

 Revision Date: 5/2013

Patient's Last Name:

Patient's First Name:

DIAGNOSIS AND MEDICAL INFORMATION

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

Does the patient meet the following criteria?

1. Does the patient have a diagnosis of homozygous familial hypercholesterolemia (HoFH)?
   ☐ Yes ☐ No
2. Is the patient at least 18 years of age?
   ☐ Yes ☐ No
3. Is the prescribing provider certified with the applicable REMS program?
   ☐ Yes ☐ No
4. Has the patient 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
5. List previous medications (include drug name/dose):

_____

_____

_____

_____

_____ _____

Prescriber Signature (Required) **Date**

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

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:
Magellan Medicaid Administration / ATTN: MAP
11013 W. Broad Street, Glen Allen, VA 23060

Virginia Medicaid Pharmacy Services Portal: http://www.virginiamedicaidpharmacyservices.com

 Revision Date: 5/2013