



**New Hampshire AIDS Drug Assistance Program  
Prior Authorization Drug Approval Form**

Juxtapid® (lomitapide)

DATE OF MEDICATION REQUEST:    /    /

**SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED**

LAST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MEDICAID ID NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

DATE OF BIRTH:

				-					-				
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GENDER:  Male  Female

Drug Name

Strength

Dosing Directions

Length of Therapy

**SECTION II: PRESCRIBER INFORMATION**

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

				-					-				
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FAX NUMBER:

				-					-				
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**SECTION III: CLINICAL HISTORY**

- Please list the diagnosis for which this medication is being requested and confirmation test, if applicable:  
\_\_\_\_\_
- Is the prescriber a cardiologist, lipidologist, or endocrinologist or has one of these specialists  Yes  No been consulted?
- Has the patient tried and failed maximum tolerated doses of atorvastatin or rosuvastatin and  Yes  No one other cholesterol medication?
  - If yes, please list medication, dose not tolerated, and length of treatment:  
\_\_\_\_\_

(Form continued on the next page.)



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Juxtapid® (lomitapide)

DATE OF MEDICATION REQUEST:     /     /

**PATIENT LAST NAME:**

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**PATIENT FIRST NAME:**

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**SECTION III: CLINICAL HISTORY (CONTINUED)**

4. Is the patient enrolled in the Juxtapid REMS program?  Yes  No

5. Please list lipid panel results:

6. For renewal after initial 6-month request, please list recent lipid panel results:

**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.**

**PRESCRIBER'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_