DIVISION OF HEALTH CARE FINANCING AND POLICY
NEVADA MEDICAID
DRUG USE REVIEW (DUR) BOARD
PROPOSED PRIOR AUTHORIZATION CRITERIA

Juxtapid® (lomitapide) and Kynamro® (mipomersen) are a covered benefit of Nevada Medicaid for recipients who meet the criteria for coverage.

1. Coverage and Limitations:
Authorization will be given if the following criteria are met and documented:

Requests for Juxtapid® (lomitapide) and Kynamro® (mipomersen)

1. Must have **ALL** of the following:
    a. The recipient has a diagnosis of homozygous familial hypercholesterolemia, confirmed based on mutations in the low-density lipoprotein receptor (LDLR), apolipoprotein B (ApoB) or proprotein convertase subtilisin/kexin type 9 (PCSK9) gene.
    AND
    The requested medication will be used as an adjunct to a low-fat diet and other lipid-lowering treatments.
    AND
    The recipient has experienced an adverse event, allergy or inadequate response to at least two high-potency statins (atorvastatin, rosuvastatin or simvastatin), or the recipient has a contraindication to treatment with statins (documentation of contraindication is required).
    AND
    The recipient has experienced an adverse event, allergy or inadequate response to at least two other antihyperlipidemic agents, or the recipient has a contraindication to treatment with all other antihyperlipidemic agents (documentation of contraindication is required).
    AND
    The recipient has experienced an adverse event, allergy or inadequate response to low-density lipoprotein apheresis, or low-density lipoprotein apheresis is unavailable.

2. PA Guidelines:
Initial prior authorization approval will be 6 months.
Recertification approval will be for 1 year.

3. Quantity Limitations:
Juxtapid® (lomitapide): 30 capsules per 30 days
Kynamro® (mipomersen) 30 vials or pre-filled syringes per 30 days