blue of california

JUXTAPID (lomitapide)

Diagnosis Considered for Coverage:

- Homozygous Familial Hypercholesterolemia (HoFH)

Coverage Criteria:

For diagnosis listed above:

Initial treatment

- Recommended by a cardiologist or endocrinologist, **and**
- Confirmed homozygous familial hypercholesterolemia by EITHER positive genetic test for LDL-R genetic mutations confirming HoFH OR clinical evidence supporting a diagnosis of HoFH, **and**
- Being used in combination with a standard lipid lowering combination regimen (e.g. a high potency statin and a non-statin lipid lowering agent), **and**
- Dose does not exceed FDA approved dosing, **and**
- One of the following:
    - Inadequate response, intolerance, or contraindication to a PCSK9 inhibitor (e.g. Praluent, Repatha), **or**
    - Provider attestation that patient has homozygous null-null variants

Coverage Duration: 6 months

Reauthorization

- Patient is responding to therapy, **and**
- Being used in combination with a standard lipid lowering combination regimen (e.g. a high potency statin and a non-statin lipid lowering agent), **and**
- Dose does not exceed FDA approved dosing.

Coverage Duration: 6 months

Coverage Duration: see specific coverage criteria

Effective Date: 09/27/2023