Homozygous Familial Hypercholesterolemia (HFHC) Products

Effective 01/29/2014
Revised 01/09/2020

Preferred Agents
- None

Non-Preferred Agents
- Juxtapid®

Approval Criteria
- Participants 18 years of age and older AND
- Dose within maximum recommended dose (Appendix A) AND
- Documented diagnosis of homozygous familial hypercholesterolemia AND
- Adequate therapeutic trial of high potency statin (atorvastatin 80mg/day, rosuvastatin 40mg/day, atorvastatin/amlodipine 80mg-5mg/day, or atorvastatin/amlodipine 80mg-10mg/day) OR
  - Documented ADE/ADR to high potency statin therapy AND
- LDL-C remains >175mg/dL

Denial Criteria
- Participant is currently pregnant OR
- Documented diagnosis of moderate or severe hepatic impairment
- Drug Prior Authorization Hotline: (800) 392-8030

Appendix A – Dosage Limits

<table>
<thead>
<tr>
<th>Drug Description</th>
<th>Generic Equivalent</th>
<th>Dosage Limit</th>
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</thead>
<tbody>
<tr>
<td>JUXTAPID 5 MG CAPSULE</td>
<td>LOMITAPIDE</td>
<td>60 mg/day</td>
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<tr>
<td>JUXTAPID 10 MG CAPSULE</td>
<td>LOMITAPIDE</td>
<td>60 mg/day</td>
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<tr>
<td>JUXTAPID 20 MG CAPSULE</td>
<td>LOMITAPIDE</td>
<td>60 mg/day</td>
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<tr>
<td>JUXTAPID 30 MG CAPSULE</td>
<td>LOMITAPIDE</td>
<td>60 mg/day</td>
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<tr>
<td>JUXTAPID 40 MG CAPSULE</td>
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