



Missouri Pharmacy Program – Preferred Drug List



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

Drug Description	Generic Equivalent	Dosage Limit
JUXTAPID 5 MG CAPSULE	LOMITAPIDE	60 mg/day
JUXTAPID 10 MG CAPSULE	LOMITAPIDE	60 mg/day
JUXTAPID 20 MG CAPSULE	LOMITAPIDE	60 mg/day
JUXTAPID 30 MG CAPSULE	LOMITAPIDE	60 mg/day
JUXTAPID 40 MG CAPSULE	LOMITAPIDE	60 mg/day
JUXTAPID 60 MG CAPSULE	LOMITAPIDE	60 mg/day