



Missouri Pharmacy Program – Preferred Drug List



Lipotropic Agents: Homozygous Familial Hypercholesterolemia

Effective 01/29/2014

Revised 01/10/2019

Preferred Agents

Available with Clinical Edits

Non-Preferred Agents

Available with Clinical Edits

- Juxtapid®
- Kynamro®

Approval Criteria

- Diagnosis of Homozygous Familial Hypercholesterolemia (ICD-9 272.0) (ICD-10 E78.0)
- Trial and failure of High-Potency Statin therapy
 - Atorvastatin 80mg/day or
 - Rosuvastatin 40mg/day
- ADE/ADR to High-Potency Statin therapy
- LDL-C remains > 175

Denial Criteria

- Claims for patients under 18 years of age.
- Pregnancy
- Moderate or severe hepatic impairment (based on Child-Pugh category B or C) or with active liver disease, including unexplained persistent elevations of serum transaminases.
- Dosage exceeds FDA limitations
 - Juxtapid 60 mg/day
 - Kynamro 200 mg/wk
- Approval criteria not met
- Drug Prior Authorization Hotline: (800) 392-8030