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Next Review Due By: 07/2024
Policy Number: C3893-A

Juxtapid (lomitapide)

PRODUCTS AFFECTED

Juxtapid (lomitapide)

COVERAGE POLICY

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.
This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines.

Documentation Requirements:
Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

DIAGNOSIS:
Homozygous familial hypercholesterolemia (HoFH)

REQUIRED MEDICAL INFORMATION:
This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by-case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review. When the requested drug product for coverage is dosed by weight, body surface area or other member specific measurement, this data element is required as part of the medical necessity review.

A. HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA
   1. Documented diagnosis of homozygous familial hypercholesterolemia (HoFH)
      AND
   2. Laboratory documentation of member's current LDL-C while on background maximized

treatment for HoFH (within the last 3 months) [DOCUMENTATION REQUIRED]
AND

3. Documentation member is taking a maximally tolerated intensity/dose of statin OR has an FDA labeled contraindication to statins OR has serious side effects and is unable to tolerate an alternative dosing schedule (i.e., every other day dosing)
AND
4. Documentation member is taking ezetimibe 10mg daily OR has an FDA labeled contraindication or serious side effects
AND
5. Documentation member is receiving LDL-C apheresis or taking a PCSK9 inhibitor, unless contraindicated or member has a history of serious side effects
AND
6. For female members of childbearing potential, provider attests that member has had a negative pregnancy screening and has been counseled to use effective contraception during treatment and for 2 weeks after the final lomitapide dose.
AND
7. Prescriber attests member will be adherent to Juxtapid AND continue to follow a low-fat diet supplying < 20% of energy from fat
AND
8. Prescriber attests member will be adherent to Juxtapid AND continue adherence to maximally tolerated dose/intensity statin therapy, ezetimibe, and PCSK9/apheresis (unless contraindicated or serious side effects as documented above)
AND
9. Documentation the requested therapy will be administered with the following (per labeling): daily supplements that contain 400 units of vitamin E and at least 200 mg of linoleic acid, 210 mg of alpha-linolenic acid (ALA), 110 mg of eicosapentaenoic acid (EPA), and 80 mg of docosahexaenoic acid (DHA) to reduce the risk of developing a fat-soluble nutrient deficiency
AND
10. Prescriber agrees to monitoring of transaminases (ALT, AST), alkaline phosphatase, and total bilirubin prior to initiation and prior to any dose increase.
AND
11. Prescriber attests lomitapide will not be used concomitantly with evinacumab-dgnb (Evkeeza)
AND
12. Prescriber attests to (or the clinical reviewer has found that) the member not having any FDA labeled contraindications that haven't been addressed by the prescriber within the documentation submitted for review [Contraindications to Juxtapid (lomitapide) include: pregnancy, concomitant use with strong or moderate CYP3A4 inhibitors (e.g., diltiazem, fluconazole, itraconazole, ketoconazole, clarithromycin, erythromycin, HIV protease inhibitors, nefazodone), moderate or severe hepatic impairment or active liver disease including unexplained persistent abnormal liver function tests, patients with hereditary problems of galactose intolerance, the Lapp lactase deficiency, or glucose-galactose malabsorption]

CONTINUATION OF THERAPY:

A. HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA

1. Adherence to therapy at least 85% of the time as verified by Prescriber and member's medication fill history (review Rx history for compliance)
AND
2. Prescriber attests member continues to be adherent with the following therapies in conjunction with Juxtapid (lomitapide):
    a. Low fat diet
    b. Other lipid-lowering therapy (e.g., statins, ezetimibe, LDL-C apheresis)
    c. Supplement(s) that contains 400 IU vitamin E, 200 mg linoleic acid, 210 mg alpha-linoleic acid (ALA), 110 mg eicosapentaenoic acid (EPA), and 80 mg docosahexaenoic acid (DHA)

AND

3. Prescriber attests to the recommended liver enzyme laboratory testing as specified in the Juxtapid prescribing information (ALT, AST, alkaline phosphatase, total bilirubin).
   NOTE: Transaminases (alanine aminotransferase [ALT] and aspartate aminotransferase [AST]), alkaline phosphatase and total bilirubin should be measured prior to initial therapy and prior to each increase in dose or on a monthly basis (whichever occurs first). After the first year of treatment, testing should occur at a minimum of every three months.
   AND
4. Documented positive response to therapy as indicated by decrease in LDL-C OR achievement of individual LDL-C patient goal [DOCUMENTATION REQUIRED]
   AND
5. Prescriber attests a recent review of member's current medication has been completed and there is no concomitant use of moderate or strong CYP3A4 inhibitors (e.g., diltiazem, fluconazole, itraconazole, ketoconazole, clarithromycin, erythromycin, HIV protease inhibitors, nefazodone) (a contraindication)
   AND
6. Prescriber attests to or clinical reviewer has found no evidence of intolerable adverse effects or drug toxicity

DURATION OF APPROVAL:
Initial authorization: 6 months, Continuation of Therapy: 12 months

PRESCRIBER REQUIREMENTS:
Must be prescribed by a cardiologist, lipid specialist, or endocrinologist

AGE RESTRICTIONS:
18 years of age or older

QUANTITY:
Initial dose: 5 mg once daily. Titrate dose based on acceptable safety/tolerability: increase to 10 mg daily after at least 2 weeks; and then, at a minimum of 4-week intervals, to 20 mg, 40 mg, and up to the maximum recommended dose of 60 mg daily

Maximum Quantity Limits – 60 mg/day

PLACE OF ADMINISTRATION:
The recommendation is that oral medications in this policy will be for pharmacy benefit coverage and patient self-administered.

DRUG INFORMATION

ROUTE OF ADMINISTRATION:
Oral

DRUG CLASS:
Microsomal Triglyceride Transfer Protein Inhibitors

FDA-APPROVED USES:
Indicated as an adjunct to a low-fat diet and other lipid-lowering treatments, including LDL apheresis where available, to reduce low-density lipoprotein cholesterol (LDL-C), total cholesterol (TC), apolipoprotein B (apo B), and non-high-density lipoprotein cholesterol (non-HDL-C) in patients with homozygous familial hypercholesterolemia (HoFH)
Limitations of use: The safety and effectiveness of Juxtapid have not been established in patients with hypercholesterolemia who do not have HoFH, including those with heterozygous familial hypercholesterolemia (HeFH). The effect of Juxtapid on cardiovascular morbidity and mortality has not been determined.

COMPENDIAL APPROVED OFF-LABELED USES:
None

APPENDIX

APPENDIX:

FDA-approved lipid lowering medications or pharmaceutical agents			
Generic Name	**U.S. Trade Name**	**Route**	**Class**
Abbreviations: FDA = U.S. Food and Drug Administration; HMG-CoA = 3-hydroxy-3-methyl-glutaryl- coenzyme A reductase; N/A = not applicable; XL = extended release			
Atorvastatin	Lipitor®	Oral	HMG-CoA reductase inhibitor (statin)
Fluvastatin	Lescol®	Oral	HMG-CoA reductase inhibitor (statin)
Fluvastatin XL	Lescol XL®	Oral	HMG-CoA reductase inhibitor (statin)
Lovastatin	Mevacor®	Oral	HMG-CoA reductase inhibitor (statin)
Pitavastatin	Livalo®	Oral	HMG-CoA reductase inhibitor (statin)
Pravastatin	Pravachol®	Oral	HMG-CoA reductase inhibitor (statin)
Rosuvastatin	Crestor®	Oral	HMG-CoA reductase inhibitor (statin)
Simvastatin	Zocor®	Oral	HMG-CoA reductase inhibitor (statin)
Cholestyramine	Prevalite®	Oral	Bile acid sequestrant
Colesevelam	Welchol®	Oral	Bile acid sequestrant
Colestipol	Colestid®; Flavored Colestid®	Oral	Bile acid sequestrant
Ezetimibe	Zetia®	Oral	Cholesterol absorption inhibitor
Fenofibrate	Tricor®; Triglide®; Lipofen®; Fenoglide®	Oral	Fibric acid
Fenofibric acid	Fibricor®; Trilipix®	Oral	Fibric acid
Gemfibrozil	Lopid®	Oral	Fibric acid
Niacin	Niaspan®; Niacor®	Oral	Nicotinic acid
Omega-3-acid ethyl ester	Lovaza®; Omacor®	Oral	Omega-3-acid ethyl ester
Icosapent ethyl	Vascepa®	Oral	Omega-3-acid ethyl ester
Lovastatin + niacin	Advicor®	Oral	HMG-CoA reductase inhibitor (statin) + nicotinic acid
Simvastatin + ezetimibe	Vytorin®	Oral	HMG-CoA reductase inhibitor (statin) + ezetimibe
Simvastatin + niacin	Simcor®	Oral	HMG-CoA reductase inhibitor (statin) + nicotinic acid

BACKGROUND AND OTHER CONSIDERATIONS

BACKGROUND:

Familial hypercholesterolemia (FH)

- An autosomal dominant genetic disease caused by functional mutations at one of three genetic loci: 1) low-density lipoprotein cholesterol (LDL-C) receptor, 2) apo B, or 3) proprotein convertase subtilisin kexin type 9 (PCSK9), all of which are involved in the normal processing and trafficking of LDL-C.
- In the absence of genetic testing, which confirms one of these mutations, FH is defined based on clinical criteria.
- The primary goal of treatment in patients with familial hypercholesterolemia is LDL-C lowering. Homozygous FH (HoFH)
- Rare and is characterized by severe elevations of total and LDL cholesterol
- Leads to accumulation of LDL particles in plasma and premature cardiovascular disease.
- Patients with HoFH carry two of the same defective genes, while patients with the heterozygous form of the condition carry one defective gene. Individuals with familial hypercholesterolemia (FH) are at significantly increased risk for premature cardiovascular disease (CVD).
- Prevalent in approximately one out of a million individuals. Most patients with HoFH have LDL levels that are four times the normal levels (between 400-1,000 mg/dL).
- Patients with HoFH will form xanthelasmas (yellowish collection of cholesterol under the skin) and cutaneous xanthomas (larger, nodular xanthelasmas) within the first few months of years of life. Tendon xanthomas (papules found in tendons of hands, feet and achilles) and tuberous xanthomas (xanthomas over the joints) tend to develop in HoFH patients later on in life.
- Generally, treating patients with HoFH has been challenging because the patient expresses little or no LDL-receptor activity and therefore is resistant to diet modifications and most medications indicated for lowering cholesterol.
- Children with homozygous FH usually present within the first decade of life, most commonly after investigation of physical findings related to cholesterol deposition, such as tendon xanthomata, cutaneous xanthelasma, or corneal arcus, or with clinical manifestations of atherosclerotic cardiovascular disease. Individuals with the more severe homozygous form of FH (HoFH) develop clinically significant cardiovascular disease in early childhood and, if untreated, they rarely survive beyond the age of 30 years, whereas in those with the less severe heterozygous form (HeFH) the onset of significant cardiovascular disease is generally delayed until the fourth or fifth decade. It is noted by the American Heart Association that familial hypercholesterolemia (FH) is the most common of the primary hyperlipidemias, and the most clearly documented to have important cardiovascular consequences beginning in childhood.

Hence, the identification and management of FH in children is of significant consequence. Diagnosis

- No universally accepted diagnostic criteria. Formal diagnosis of FH made by applying various combinations of patient characteristics. There are 3 validated sets of diagnostic criteria include:

United States Make Early Diagnosis to Prevent Early Death (MedPed)

United Kingdom Simon Broome Familial Hypercholesterolemia Registry Dutch Lipid Clinic criteria

- Diagnosis of both homozygous and heterozygous FH is based primarily on the finding of severe LDLc elevations in the absence of secondary causes of hypercholesterolemia with triglyceride levels that are within the reference range or mildly elevated and HDL cholesterol (HDLc) levels that are within the reference range or slightly low. Definitive diagnosis can be made only with gene or receptor analysis.
- HoFH can be distinguished from heterozygous FH clinically by the much more extreme elevations

in LDL and can be confirmed by either genetic characterization of the LDL receptor mutations (from leukocytes) or by quantification of LDL receptor activity (from skin fibroblasts).

TREATMENT OPTIONS

The goal of FH treatment is to reduce the risk of CHD or risk of a CHD-equivalent condition (e.g., carotid artery disease, diabetes, peripheral arterial disease).

Management of homozygous FH

- Lifestyle changes: Recommended for cardiovascular benefits
- High doses of HMG-CoA reductase inhibitors (statins) combined with bile acid sequestrants, ezetimibe, and niacin
- Estrogen replacement therapy in postmenopausal women
- LDL apheresis for selective removal of lipoproteins that contain apo-B (when the LDL receptors are absent or non-functional)
- Surgical procedures: Portacaval anastomosis or Liver transplantation (rarely)

Other FDA-approved pharmacological therapies indicated for the treatment of HoFH include certain statins (atorvastatin, rosuvastatin and simvastatin), ezetimibe/simvastatin and ezetimibe in combination with either atorvastatin or simvastatin. The 2002 Adult Treatment Panel (ATP) III guidelines from the National Cholesterol Education Program (NCEP) lists statins and nicotinic acid as an adjunct to other lipid-lowering treatments such as LDL aphresis (process which removes VLDL and LDL from the plasma) or when such treatments are unavailable as therapeutic considerations in patients with HoFH.

FH patients without cardiovascular disease who do not achieve LDL-C < 200 mg/dL (5.17 mmol/L) or those with established disease who do not achieve an LDL-C < 160 mg/dL (4.10 mmol/L) after optimal drug therapy and LDL-apheresis, we suggest adding lomitapide or mipomersen (Grade 2C). For patients who are not candidates for or refuse LDL-apheresis or liver transplantation, lomitapide or mipomersen should be considered as additional pharmacologic therapy. (UpToDate 2019)

It should be noted that the safety and efficacy of Juxtapid (lomitapide) in children have not been established.

American Heart Association recommendations for pediatric patients regarding homozygous familial hypercholesterolemia patients are as follows:

- complete cardiovascular assessment at diagnosis along with ongoing surveillance for cardiovascular disease
- treatment should be instituted as soon as possible
- therapy for most patients is weekly or biweekly plasmapheresis, preferably LDL apheresis
- high-dose statins recommended in combination with a cholesterol absorption inhibitor
- low-dose anticoagulation may also be indicated

Juxtapid (lomitapide) is a first-in-class microsomal triglyceride transfer protein (MTP) inhibitor. Lomitapide is a microsomal triglyceride transfer protein inhibitor used to reduce low-density lipoprotein cholesterol (LDL-C), total cholesterol, apolipoprotein B (apo-B), and non-high-density lipoprotein cholesterol in patients with homozygous familial hypercholesterolemia (HoFH). Juxtapid is intended for use in combination with a low-fat diet, supplying < 20% of energy from fat, and other lipid-lowering treatments. Juxtapid directly binds and inhibits microsomal triglyceride transfer protein (MTP), which resides in the lumen of the endoplasmic reticulum, thereby preventing the assembly of apo B-containing lipoproteins in enterocytes and hepatocytes. This inhibits the synthesis of chylomicrons and VLDL. The inhibition of the synthesis of VLDL leads to reduced levels of plasma LDL-C. Lomitapide, a synthetic lipid-lowering agent, directly binds and inhibits microsomal triglyceride transfer protein, which resides in the lumen of the

endoplasmic reticulum, thereby preventing the assembly of apo B–containing lipoproteins in enterocytes and hepatocytes. This inhibits the synthesis of chylomicrons and very low-density lipoprotein (VLDL). The inhibition of the synthesis of VLDL leads to reduced levels of plasma LDL-C.

Guideline recommendations: Lomitapide may be useful in patients with HoFH not responsive to PCSK9 inhibitor therapy [AACE (Jellinger 2017)]. In addition, lomitapide may be considered in patients with ASCVD and baseline LDL-C ≥190 mg/dL who have an inadequate response to statins (with or without ezetimibe and PCSK9 inhibitors) [ACC (Lloyd-Jones 2016)].

PUBLISHED CLINICAL TRIALS

To date, only one Phase III clinical trial has been published supporting lomitapide in the treatment of HoFH.

Approval was based on data from a Phase III, 78-week, single-arm, open-label trial that evaluated the use of lomitapide in 29 adult patients with homozygous familial hypercholesterolemia. Patients were treated with lomitapide at an initial dose of 5 mg daily and gradually escalated to doses of 10mg, 20mg, 40mg, up to 60mg, based on tolerability and acceptable liver enzyme levels.

The primary endpoint was LDL-C change from baseline to 26 weeks and patients were followed an additional 52 weeks to assess safety. Concomitant lipid-lowing therapies were stable during the efficacy phase but could change during the safety phase. Apheresis was allowed and LDL-C response allowed it to be stopped in 3 patients and the interval extended in another 3. There was a50% decrease in LDL- C at 26 weeks (p <0.0001) to a median level of 169 mg/dL. Eight patients achieved LDL-C levels <100mg/dL with 4 of these concomitantly receiving apheresis.

The study did not evaluate CHD events. Results from the study showed that when lomitapide was added onto existing lipid-lowering treatment, LDL cholesterol was significantly reduced from a baseline average of 336 mg/dL to 190 mg/dL (40% reduction) at week 26. In 23 patients, LDL cholesterol was reduced by an average of 50% at week 26. Among the 23 patients who completed the trial, mean LDL cholesterol decreased from a baseline of 336 mg/dL to 166 mg/dL after 26 weeks, 197 mg/dL at 56 weeks, and 208 mg/dL at 78 weeks, all significant reductions.

The most common adverse events were gastrointestinal, reported by 27 (93%) of 29 patients. Adverse events reported by ≥5% of patients with HoFH include diarrhea, nausea, vomiting, dyspepsia, abdominal pain, weight loss, abdominal discomfort, abdominal distension, constipation, flatulence, increased alanine aminotransferase, chest pain, influenza, nasopharyngitis and fatigue.

Available treatment guidelines support the use of high-dose statins, low density lipoprotein apheresis and other cholesterol lowering agents (e.g., ezetimibe), often as part of combination regimens to reach cholesterol goals.

American Heart Association

The 2006 American Heart Association scientific statement on cardiovascular risk reduction in high-risk pediatric patients recommends that children with homozygous FH receive early initiation of combined therapy including LDL apheresis, high dose statin therapy, and a cholesterol absorption inhibitor. UpToDate experts on homozygous FH also recommend this approach for both children and adults.

□ Drug Therapy of High-Risk Lipid Abnormalities in Children and Adolescents: a Scientific\ Statement from the American Heart Association (2007) may be given as necessary, although compliance with these agents tends to be challenging.

- For children meeting criteria for lipid-lowering drug therapy, a statin is recommended as first-line treatment. The choice of statin is dependent upon preference but should be initiated at the lowest dose once daily, usually at bedtime.
- For patients with high-risk lipid abnormalities, the presence of additional risk factors or high-risk conditions may reduce the recommended LDL level for initiation of drug therapy and the desired target LDL levels. Therapy may also be considered for initiation in patients <10 years of age.
- Additional research regarding drug therapy of high-risk lipid abnormalities in children is needed to evaluate the long-term efficacy and safety and impact on the atherosclerotic disease process.

American Association of Clinical Endocrinologists (AACE 2012)
In 2012, the American Association of Clinical Endocrinologists (AACE) published guidelines for the management of dyslipidemia and prevention of atherosclerosis.

AACE also includes lipid screening in the pediatric populations and recommend that children older than two years and adolescents older than 16 years be evaluated every three to five years and every five years, respectively, if they have CAD risk factors or a family history of premature CAD or dyslipidemia.
AACE supports the use of apolipoprotein B (apo B) in evaluating lipid status. They recommend an optimal apo B < 90 mg/dL for patients at risk of CAD, while patients with established CAD or diabetes who have one or more additional risk factors should have an apo B < 80 mg/dL.

Fibrates for recommended for treatment of triglycerides > 500 mg/dL. Niacin can be used for reducing triglycerides, increasing HDL-C, and reducing LDL-C. Omega-3 fish oil (2 to 4 g) of can be used, as adjunct to fibrates or niacin if necessary, to achieve satisfactory triglyceride lowering. AACE recommends bile acid sequestrants for reducing LDL-C and apo B and modestly increasing HDL-C, but they may increase triglycerides.

Cholesterol absorption inhibitors are effective as monotherapy in reducing LDL-C and apo B. In addition, combination therapy with statins can be used.

AACE recommends pharmacotherapy for children and adolescents older than eight years who do not respond sufficiently to lifestyle modification and particularly for those with either LDL-C ≥ 190 mg/dL, or LDL-C ≥160 mg/dL and the presence of two or more cardiovascular risk factors, or a family history of premature CAD.
These guidelines also address the unique challenges associated with atherosclerosis and heart disease in women. They recommend the following pharmacotherapy for all women at high risk: lipid-lowering pharmacotherapy (preferably with a statin) regardless of LDL-C level, and niacin or fibrate therapy in the presence of low HDL-C or elevated non–HDL-C; for all women at intermediate risk: lipid-lowering pharmacotherapy (preferably with a statin) in the presence of an LDL-C level greater than 130 mg/dL, and niacin or fibrate therapy in the presence of low HDL-C or elevated non–HDL-C after LDL-C goal is reached.

National Heart Lung and Blood Institute
Expert Panel on Integrated Guidelines for Cardiovascular Health and Risk (2011)
Specific recommendations regarding the management of familial hypercholesterolemia include:

- Children with homozygous familial hypercholesterolemia and extremely elevated LDL-C levels (> 500 mg/dL) have undergone effective LDL-C lowering therapy with biweekly LDL apheresis under the care of lipid specialists in academic medical centers.
- Statins have been shown to reduce LDL-C in children and adolescents with marked LDL-C elevation or familial hypercholesterolemia.
- Plant sterol esters and/or plant stanol esters up to 2 g/day as replacement for usual fat sources can be used after two years of age in children with familial hypercholesterolemia National Cholesterol Education Program (NCEP)

The 2002 Adult Treatment Panel (ATP) III guidelines from the National Cholesterol Education Program (NCEP) lists statins and nicotinic acid as an adjunct to other lipid-lowering treatments such as LDL apheresis (process which removes VLDL and LDL from the plasma) or when such treatments are unavailable as therapeutic considerations in patients with HoFH.

National Lipid Association (NLA)
Management of familial hypercholesterolemias in adult patients: recommendations from the National Lipid Association Expert Panel on Familial Hypercholesterolemia (2011)

Low-fat, low-cholesterol diet and tobacco cessation, physical activity and maintenance of a healthy body weight are recommended.

For adult familial hypercholesterolemia patients, initial treatment is the use of moderate to high doses of high-potency statin are recommended to reduce LDL-C at least 50% from baseline. Low potency statins are generally inadequate for familial hypercholesterolemia patients. If a patient is not able to meet the LDL-C goal with statin, additional agents such as ezetimibe, bile acid sequestrants, or niacin may be added to statin therapy.

- If the initial statin is not tolerated, consider changing to an alternative statin, or every-other-day statin therapy.
- If initial statin therapy is contraindicated or poorly tolerated, ezetimibe, a bile acid sequestrant (colesevelam) or niacin may be considered.
- For patients who cannot use a statin, most will require combination drug therapy.
- If the patient is not at LDL-C treatment goal with the maximum available and tolerable dose of statin, then combine with ezetimibe, niacin, or a bile acid sequestrant (colesevelam preferred).

Decisions regarding selection of additional drug combinations should be based on concomitant risk factors for myopathy, concomitant medications, and the presence of other disease conditions and lipid abnormalities.
In patients who, after six months, do not have an adequate response to maximum tolerated drug therapy, LDL apheresis is indicated according to these guidelines:
Functional homozygous familial hypercholesterolemia patients with LDL-C ≥ 300 mg/dL (or non- HDL-C ≥ 330 mg/dL).
Functional heterozygous familial hypercholesterolemia patients with LDL-C ≥ 300 mg/dL (or non-HDL-C ≥330 mg/dL) and one or fewer risk factors.
Functional heterozygous familial hypercholesterolemia patients with LDL-C ≥ 200 mg/dL (or non-HDL-C ≥ 230 mg/dL) and high-risk characteristics such as two or more risk factors or high lipoprotein (a) ≥50 mg/dL using an isoform insensitive assay.
Functional heterozygotes with LDL-C ≥ 160 mg/dL (or non-HDL-C ≥ 190 mg/dL) and very high-risk characteristics (established CHD, other cardiovascular disease, or diabetes).

LDL-C apheresis is recommended for patients with HoFH who have an LDL-C level of at least 300 mg/dL despite maximal drug therapy for at least six months.
Liver transplantation is rarely utilized due to its risks, but it may be beneficial in patients who fail to respond to all other therapies because it provides normal LDL-C receptors and often leads to a significant lowering of LDL cholesterol.

Juxtapid REMS Program
Because of the risk of hepatotoxicity associated with JUXTAPID therapy, JUXTAPID is available through a restricted program under the REMS. Under the JUXTAPID REMS, only certified healthcare providers and pharmacies may prescribe and distribute JUXTAPID. Further information is available at www.JUXTAPIDREMSProgram.com or by telephone at 1-85-JUXTAPID (1-855-898-2743).

CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:
All other uses of Juxtapid (lomitapide) are considered experimental/investigational and therefore, will follow Molina's Off- Label policy. Contraindications to Juxtapid (lomitapide) include: pregnancy, Co-administration with moderate (e.g., ciprofloxacin, diltiazem, fluconazole) or strong CYP3A4 inhibitors (such as boceprevir, clarithromycin, conivaptan, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, mibefradil, nefazodone, nelfinavir, posaconazole, ritonavir, saquinavir, telaprevir, telithromycin, voriconazole), Moderate or severe hepatic impairment (Child- Pugh class B or C), active liver disease, including unexplained persistent elevations of serum transaminases, patients with hereditary problems of galactose intolerance, the Lapp lactase deficiency, or glucose-galactose malabsorption.

OTHER SPECIAL CONSIDERATIONS:
Black box warning: Hepatotoxicity. Juxtapid can cause elevations in transaminases. Juxtapid also increases hepatic fat (hepatic steatosis) with or without concomitant increases in transaminases. Juxtapid is a pregnancy category X.

CODING/BILLING INFORMATION

Note: 1) This list of codes may not be all-inclusive. 2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement

HCPCS CODE	DESCRIPTION
NA	

AVAILABLE DOSAGE FORMS:
Juxtapid CAPS 5MG
Juxtapid CAPS 10MG
Juxtapid CAPS 20MG
Juxtapid CAPS 30MG
Juxtapid CAPS 40MG
Juxtapid CAPS 60MG

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SUMMARY OF REVIEW/REVISIONS	DATE
REVISION- Notable revisions: Required Medical Information Continuation of Therapy Prescriber Requirements FDA-Approved Uses Background Contraindications/Exclusions/Discontinuation Other Special Considerations References	Q3 2023
REVISION- Notable revisions: Required Medical Information Continuation of Therapy Prescriber Requirements Quantity References	Q4 2022
Q2 2022 Established tracking in new format	Historical changes on file