PRIOR AUTHORIZATION POLICY

POLICY: Homozygous Familial Hypercholesterolemia – Juxtapid Prior Authorization Policy
- Juxtapid® (lomitapide capsules – Chiesi)

REVIEW DATE: 03/11/2026

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Juxtapid, a microsomal triglyceride transfer protein inhibitor, is indicated as an adjunct to a low-fat diet and exercise and other low-density lipoprotein cholesterol (LDL-C) therapies to reduce LDL-C in adults and pediatric patients ≥ 2 years of age with **homozygous familial hypercholesterolemia** (HoFH).[1] The safety and efficacy of Juxtapid have not been established in patients with hypercholesterolemia who do not have HoFH, including those with heterozygous familial hypercholesterolemia (HeFH). Also, the effect of Juxtapid on cardiovascular (CV) morbidity and mortality have not been determined.

Repatha® (evolocumab subcutaneous injection) and Praluent® (alirocumab subcutaneous injection), two proprotein convertase subtilisin kexin type 9 (PCSK9) inhibitors, are indicated as an adjunct to diet and other LDL-lowering therapies (e.g., statins, ezetimibe, LDL apheresis) in patients with HoFH who require additional LDL-

C lowering; Praluent is specifically indicated for use in adults, whereas Repatha can be used in adult and pediatric patients ≥ 10 years of age with HoFH.[2,3] Leqvio® (inclisiran subcutaneous injection) is a small interfering RNA (siRNA) directed to PCSK9 mRNA that is also indicated in pediatric patients ≥ 12 years of age with HoFH.[4] It is notable that patients known to have two LDL-receptor negative alleles (little or no residual function) did not respond or had minimal response to Repatha and Praluent; these patients were excluded in the pivotal studies that evaluated Leqvio for this indication.[2-4] Simvastatin, atorvastatin, and rosuvastatin are statins that are indicated for the management of patients with HoFH.[5-7] Ezetimibe is also indicated for use in combination with atorvastatin or simvastatin in patients with HoFH.[8] Ezetimibe/simvastatin tablets are indicated for use in HoFH.[9] Evkeeza® (evinacumab-dgnb intravenous infusion), an angiopoietin-like 3 inhibitor, is also indicated as an adjunct to other LDL-C lowering therapies for the treatment of HoFH in patients ≥ 1 years of age.[10]

Disease Overview

Familial hypercholesterolemias (FH), including HeFH and HoFH, are a group of inherited disorders that cause markedly elevated LDL-C levels.[11,12] HoFH is rare, affecting approximately 1 in 300,000 to 1,000,000 individuals, and is most commonly caused by impaired LDL receptor function, resulting in little to no LDL-C clearance. FH is associated with variations in the LDL receptor, apolipoprotein B, or PCSK9 genes and may present with tendon or cutaneous xanthomas, sometimes beginning in childhood. Patients with FH are at very high risk for premature atherosclerotic cardiovascular disease (ASCVD). Treatment targets generally aim for LDL-C < 100 mg/dL or < 70 mg/dL in adults with ASCVD or additional risk factors. High-intensity statin therapy is a first-line recommendation, with ezetimibe and PCSK9 inhibitors added as needed; patients with HoFH often require combination therapy, with the addition of agents such as Juxtapid, Evkeeza, or LDL apheresis.

HoFH can be diagnosed using genetic or clinical criteria, with untreated LDL-C > 400 mg/dL and early xanthomas or elevated LDL-C in parents being strongly suggestive.[11] In the digenic form, one parent may have normal LDL-C levels and the other may have LDL-C levels consistent with HoFH.

Guidelines

- **American College of Cardiology Expert Consensus Decision Pathway on the Role of Non-statin Therapies (2022):** Specialized therapies, one of which includes Juxtapid, may be needed to control LDL-C in certain patients (e.g., those with HoFH) who have had an inadequate response to statins, with or without ezetimibe, and PCSK9 inhibitors.[13]
- **European Atherosclerosis Society (2023):** Clinical guidance by this organization recommends lipid-lowering therapy be initiated with high-intensity statin therapy and ezetimibe.[12] A PCSK9 inhibitor can be added as well. If patients are not at LDL-C goals, other agents can be alternatives as well (e.g., Juxtapid, Evkeeza). Lipoprotein apheresis may also be considered. The goal is to reduce LDL-C to < 115 mg/dL in children and adolescents, < 70 mg/dL in adults if no major ASCVD risk factors are present, and < 55 mg/dL if patients have ASCVD or major ASCVD risk factors.

Safety

Juxtapid has a Boxed Warning regarding the risk of hepatotoxicity.[1] Juxtapid may cause elevations in liver transaminases. Also, Juxtapid increases hepatic fat (hepatic steatosis) with or without concomitant increases in transaminases. Due to the risk of hepatotoxicity, Juxtapid is available only through a Risk Mitigation and Strategy Program (REMS). Juxtapid may cause fetal harm when given to a pregnant woman based on findings suggesting teratogenicity in animals. Females of reproductive potential should obtain a negative pregnancy test before Juxtapid initiation and should utilize effective contraception during Juxtapid use and for 2 weeks after the final dose.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Juxtapid. All approvals are provided for the duration noted below. A patient who has previously met Initial Therapy criteria for Juxtapid for the requested indication under the Coverage Review Department and is currently receiving Juxtapid is only required to meet continuation of therapy criteria (i.e., currently receiving therapy). If past criteria have not been met under the Coverage Review Department and the patient is currently receiving Juxtapid, or is restarting Juxtapid, Initial Therapy criteria must be met.

- **Juxtapid® (lomitapide capsules - Chiesi)**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indication

1. **Homozygous Familial Hypercholesterolemia (HoFH).** Approve for 1 year if the patient meets ONE of the following (A or B):
   - **A)** Initial Therapy. Approve if the patient meets ALL of the following (i, ii, and iii):
     - **i.** Patient meets ONE of the following (a, b, or c):
       - **a)** The diagnosis has been confirmed by genetic testing; OR
         Note: Examples include pathogenic variants at the low-density lipoprotein receptor (*LDLR*), apolipoprotein B (*APOB*), proprotein convertase subtilisin kexin type 9 (*PCSK9*), or low-density lipoprotein receptor adaptor protein 1 (*LDLRAP1*) gene.
       - **b)** Patient has an untreated low-density lipoprotein cholesterol (LDL-C) level > 400 mg/dL AND meets ONE of the following [(1) or (2)]:
         Note: Untreated refers to prior to therapy with any antihyperlipidemic agent.
         - **(1)** Patient had a clinical manifestation of homozygous familial hypercholesterolemia before 10 years of age; OR
           Note: Examples of clinical manifestations of homozygous familial hypercholesterolemia are cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas, or xanthelasma.

(2) At least one parent of the patient had untreated LDL-C levels or total cholesterol levels consistent with familial hypercholesterolemia; OR
Note: An example of familial hypercholesterolemia is an untreated low-density LDL-C level ≥ 190 mg/dL and/or an untreated total cholesterol level > 250 mg/dL.

c) Patient has a treated LDL-C level ≥ 300 mg/dL AND meets ONE of the following [(1) or (2)]:
Note: Treated refers to after therapy with at least one antihyperlipidemic agent. Some examples of antihyperlipidemic agents include statins (e.g., atorvastatin, rosuvastatin, lovastatin, simvastatin, pravastatin), ezetimibe, PCSK9 inhibitors (i.e., Repatha [evolocumab subcutaneous injection], Praluent [alirocumab subcutaneous injection]), and Evkeeza (evinacumab-dgnb intravenous infusion).

(1) Patient had a clinical manifestation of homozygous familial hypercholesterolemia before 10 years of age; OR
Note: Examples of clinical manifestations of homozygous familial hypercholesterolemia are cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas, or xanthelasma.

(2) At least one parent of the patient had untreated LDL-C levels or total cholesterol levels consistent with familial hypercholesterolemia; AND
Note: An example of familial hypercholesterolemia is an untreated LDL-C ≥ 190 mg/dL and/or an untreated total cholesterol > 250 mg/dL.

ii. Patient meets ONE of the following (a or b):

a) Patient is 2 years to < 10 years of age; OR

b) Patient is ≥ 10 years of age and meets BOTH of the following [(1) and (2)]:

(1) Patient meets ONE of the following [(a) or (b)]:

(a) Patient meets BOTH of the following ([1] and [2]):

[1] Patient has tried one proprotein convertase subtilisin kexin type 9 (PCSK9) inhibitor for ≥ 8 continuous weeks; AND
Note: Examples of PCSK9 inhibitors include Repatha (evolocumab subcutaneous injection) and Praluent (alirocumab subcutaneous injection).

[2] The LDL-C after this PCSK9 inhibitor therapy remains ≥ 70 mg/dL; OR

(b) Patient is known to have two LDL-receptor negative alleles; AND

iii. Patient meets ONE of the following (a or b):

a) Patient meets ALL of the following [(1), (2), and (3)]:

(1) Patient has tried one high-intensity statin therapy (i.e., atorvastatin ≥ 40 mg daily; rosuvastatin ≥ 20 mg daily [as a single entity or as a combination product]); AND

(2) Patient has tried one high-intensity statin along with ezetimibe (as a single-entity or as a combination product) for ≥ 8 continuous weeks; AND

(3) Low-density lipoprotein cholesterol level after this treatment regimen remains ≥ 70 mg/dL; OR

b) Patient has been determined to be statin intolerant by meeting ONE of the following [(1) or (2)]:

(1) Patient experienced statin-related rhabdomyolysis; OR
Note: Rhabdomyolysis is statin-induced muscle breakdown that is associated with markedly elevated creatine kinase levels (at least 10 times the upper limit of normal), along with evidence of end organ damage which can include signs of acute renal injury (noted by substantial increases in serum creatinine [Scr] levels [a ≥ 0.5 mg/dL increase in Scr or doubling of the Scr] and/or myoglobinuria [myoglobin present in urine]).

(2) Patient meets ALL of the following [(a), (b), and (c)]:

(a) Patient experienced skeletal-related muscle symptoms; AND
Note: Examples of skeletal-related muscle symptoms include myopathy (muscle weakness) or myalgia (muscle aches, soreness, stiffness, or tenderness).

(b) The skeletal muscle-related symptoms occurred while receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or combination products); AND

(c) When receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination products), the skeletal-related muscle symptoms resolved upon discontinuation of each respective statin therapy (atorvastatin and rosuvastatin); OR
Note: Examples of skeletal-related muscle symptoms include myopathy and myalgia.

B) Patient Currently Receiving Juxtapid. Approve if according to the prescriber, the patient has experienced a response to therapy.
Note: Examples of a response to therapy include decreasing low-density lipoprotein cholesterol (LDL-C), total cholesterol, non-high-density lipoprotein (non-HDL-C), or apolipoprotein B levels. Also, if the patient is currently receiving the requested therapy but has not previously received approval of Juxtapid for this specific indication through the Coverage Review Department, review under criteria for Initial Therapy. If the patient is restarting therapy with Juxtapid, Initial Therapy criteria must be met.

CONDITIONS NOT COVERED

- **Juxtapid® (lomitapide capsules - Chiesi)**

is(are) considered not medically necessary for ANY other use(s) including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. **Heterozygous Familial Hypercholesterolemia (HeFH).** The safety and effectiveness of Juxtapid have not been established in patients with hypercholesterolemia who do not have HoFH, including those with HeFH.[1]

2. **Hyperlipidemia.** The safety and efficacy of Juxtapid have not been established in patients with hypercholesterolemia who do not have HoFH.[1]
   Note: This is not associated with homozygous familial hypercholesterolemia and may be referred to as combined hyperlipidemia, hypercholesterolemia (pure, primary), mixed dyslipidemia, or increased/elevated low-density lipoprotein cholesterol (LDL-C) levels.

REFERENCES

1. Juxtapid® capsules [prescribing information]. Parma, Italy: Chiesi; February 2026.
2. Leqvio® subcutaneous injection [prescribing information]. East Hanover, New Jersey: Novartis; February 2026.
3. Repatha® subcutaneous injection [prescribing information]. Thousand Oaks, CA: Amgen; October 2025.
4. Praluent® subcutaneous injection [prescribing information]. Tarrytown, NY: Regeneron; August 2025.
5. Zocor® tablets [prescribing information]. Morgantown, WV; Viatris/Organon; August 2023.
6. Lipitor® tablets [prescribing information]. Morgantown, WV; Viatris; Pfizer; April 2024.
7. Crestor® tablets [prescribing information]. Wilmington, DE: AstraZeneca; July 2024.
8. Zetia® tablets [prescribing information]. Jersey City, NJ: Organon; February 2024.
9. Vytorin® tablets [prescribing information]. Jersey City, NJ: Organon; March 2024.
10. Evkeeza® intravenous infusion [prescribing information]. Tarrytown, NY: Regeneron; September 2025.
11. Cuchel M, Raal FJ, Hegele RA, et al. 2023 update on European Atherosclerosis Society Consensus Statement on Homozygous Familial Hypercholesterolaemia: new treatments and clinical guidance. *Eur Heart J*. 2023;44:2277-2291.
12. Raal FJ, Hovingh GK, Catapano AL. Familial hypercholesterolemia treatments: guidelines and new therapies. *Atherosclerosis*. 2018;277:483-492.
13. Lloyd-Jones DM, Morris PB, Ballantyne CM, et al. 2022 ACC Expert Consensus Decision Pathway on the Role of Non-Statin Therapies for LDL-Cholesterol Lowering in the Management of Atherosclerotic Cardiovascular Disease Risk. *J Am Coll*. 2022;80(14):1366-1418.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	**Policy Statement:** The statement that "the agent is prescribed by or in consultation with a physician who specializes in the condition being treated" was removed. In addition, the following changes were made: **Homozygous Familial Hypercholesterolemia:** For Initial Therapy, the specialist physician requirement was removed. The requirement that the patient has had genetic confirmation by two mutant alleles at the low-density lipoprotein receptor, apolipoprotein B, proprotein convertase subtilisin kexin type 9, or low-density lipoprotein receptor adaptor protein 1 gene locus was changed to state that the patient has phenotypic confirmation of homozygous familial hypercholesterolemia and the above examples moved to a Note. The diagnostic criterion which stated that the patient has an untreated low-density lipoprotein cholesterol level > 500 mg/dL was changed to > 400 mg/dL. The criterion (which is in two places [those with an untreated low-density lipoprotein cholesterol level > 400 mg/dL and a treated low-density lipoprotein cholesterol level ≥ 300 mg/dL]) that both parents of the patient had untreated low-density lipoprotein cholesterol levels or total cholesterol levels consistent with heterozygous familial hypercholesterolemia was changed to state that	05/08/2024

	at least one parent of the patient had untreated low-density lipoprotein cholesterol levels or total cholesterol levels consistent with familial hypercholesterolemia. The related Note that "An example of heterozygous familial hypercholesterolemia in both parents would be if both had an untreated low-density lipoprotein cholesterol level ≥ 190 mg/dL and/or an untreated total cholesterol level > 250 mg/dL" was changed to state "An example of familial hypercholesterolemia is an untreated low-density lipoprotein cholesterol level ≥ 190 mg/dL and/or an untreated total cholesterol level > 250 mg/dL." For a Patient Currently Receiving the Medication, the requirement that the "prescribing physician" notes that the patient has experienced a response to therapy was changed to "prescriber."	
Annual Revision	**Homozygous Familial Hypercholesterolemia:** For Initial Therapy, the phrase "phenotypic confirmation of homozygous familial hypercholesterolemia" was replaced with "The diagnosis has been confirmed by genetic testing." Also, "apo B" was changed to "APOB."	05/28/2025
Annual Revision	**Homozygous Familial Hypercholesterolemia:** For Initial Therapy, the age of approval was changed to ≥ 2 years of age; previously, it was ≥ 18 years of age. The requirement for a patient to try a proprotein convertase subtilisin kexin type 9 (PCSK9) inhibitor was updated to only apply for patients ≥ 10 years of age.	03/11/2026