maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST
Hyperlipidemia Medications

PATIENT:
Name_____
Address:_____
City, State, Zip_____
D.O.B._____
Member ID: _____

Prescriber:
Name_____
Address_____
City, State, Zip_____
Phone _____
Fax_____
NPI _____

Medication Requested: _____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A Please answer the following questions

1. Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?
   - ❑ INITIAL → ***please answer questions 2 – 8***
   - ❑ CONTINUATION → ***please answer question 9***
2. What is the requested medication?
   - ❑ Rosuvastatin → ***please answer questions 3 – 5***
   - ❑ Lovaza → ***please answer questions 6 – 8***
   - ❑ Vascepa → ***please answer questions 6 – 8***
   - ❑ All other medications ***(please specify):***_____

3. ❑ Yes ❑ No Has the patient tried and failed to achieve LDL goal on a compliant regimen of maximum tolerated dose of atorvastatin?
4. ❑ Yes ❑ No Does the patient require a high intensity statin (for example, diagnosis of familial hypercholesterolemia or high ASCVD risk per provider evaluation) AND had a trial and failure of atorvastatin?
5. ❑ Yes ❑ No Will the requested medication be used as an add-on to lifestyle interventions to include diet and exercise?
6. ❑ Yes ❑ No Is the requested medication being treated for severe hypertriglyceridemia (triglyceride level GREATER THAN or EQUAL to 500 mg/dL)?
7. ❑ Yes ❑ No Has the patient tried and failed over-the-counter (OTC) fish oil and AT LEAST one other formulary medication such as fenofibrate, fenofibric acid, gemfibrozil, or niacin?
8. ❑ Yes ❑ No Does the patient have a contraindication to ALL formulary agents?
9. ❑ Yes ❑ No Does the patient have an improvement in fasting lipids?

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If you have any questions, call: 800-753-2851

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Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE

FAX COMPLETED FORM TO: 877-251-5896

If you have any questions, call: 800-753-2851