



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

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Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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questions, call:
800-753-2851