



## PRIOR AUTHORIZATION REQUEST

### HYPERLIPIDEMIA

**Patient Information:**

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

**Prescriber Information:**

Name:	
NPI:	
Phone Number:	
Fax Number:	
Address:	
City, State, Zip:	

**Requested Medication**

Rx Name:	
Rx Strength:	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for ALL PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements. MDH transmittals and updates to treatment guidelines.

1	Is this a request for INITIAL or CONTINUATION of therapy with the requested medication? <input type="checkbox"/> Initial (If checked, go to 2) <input type="checkbox"/> Continuation (If checked, go to 8)	
2	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes      No

**If you have any  
questions, call:  
1-888-258-8250**

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3	Will the requested medication be used as an add-on to lifestyle interventions to include diet and exercise? [If no, no further questions.]	Yes	No
4	Is the requested medication being used for severe hypertriglyceridemia (triglyceride level GREATER THAN or EQUAL to 500 mg/dL)? [If no, no further questions.]	Yes	No
5	Has the patient tried and failed over-the-counter (OTC) fish oil? [If no, no further questions.]	Yes	No
6	Has the patient tried and failed at LEAST one other formulary medication such as fenofibrate, fenofibric acid, gemfibrozil, or niacin? [If yes, no further questions.]	Yes	No
7	Does the patient have a contraindication to ALL formulary agents: A) fenofibrate, B) fenofibric acid, C) gemfibrozil, D) niacin? [No further questions.]	Yes	No
8	Does the patient have an improvement in fasting lipids?	Yes	No

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

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### **SECTION B:** Physician Signature

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PHYSICIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**FAX COMPLETED FORM TO: 1-833-896-0656**

**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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1-888-258-8250**

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