

PRIOR AUTHORIZATION REQUEST FORM

BRAND STATINS

Altoprev®, FloLipid®, Livalo®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

For Commercial Groups, Individual & Family Plans please fax request to 888-509-8142.

For Healthy U Medicaid, University of Utah Health Employees please fax request to 844-316-3655

If you have prior authorization questions, please call for assistance: Healthy U: 866-236-5935, University of Utah Health Employees: 866-861-6178, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: Altoprev® (lovastatin extended-release), FloLipid® (simvastatin suspension),
 Livalo® (pitavastatin)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
ALTOPREV®			
1. Is the request for Altoprev®?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the request for the treatment of primary hypercholesterolemia, primary or secondary prevention of cardiovascular events, or to slow coronary atherosclerosis progression?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Has the member had a 90 day trial and failure or intolerance of at least 4 other generic statin therapies (e.g. simvastatin, atorvastatin, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Has the member had a 90 day trial and failure of ezetimibe?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
FLOLIPID®			
1. Is the request for FloLipid®?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the request for treatment of primary hypercholesterolemia, hypertriglyceridemia, primary dysbetalipoproteinemia, homozygous familial hyperlipidemia, primary or secondary prevention of cardiovascular events, or heterozygous familial hypercholesterolemia in adolescent patients?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

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3. Is the member unable to swallow or has severe dysphagia that prevents the member from taking solid oral dosage forms?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
LIVALO®			
1. Is the request for Livalo®?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the request for treatment of primary hypercholesterolemia or hypertriglyceridemia?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Has the member had a 90 day trial and failure or intolerance of at least 4 other high-intensity generic statin therapies (e.g. rosuvastatin, atorvastatin)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Has the member had a 90 day trial and failure of ezetimibe?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the therapy shown to be effective with an improvement in condition?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Does the member show a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy PHARM- 071
 Origination Date: 02/23/2018
 Reviewed/Revised Date: 03/25/2020
 Next Review Date: 03/25/2021
 Current Effective Date: 06/28/2020

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