

## LIPOTROPICS, STATINS PRIOR AUTHORIZATION FORM

- Please submit **all** requested documentation with this request. Incomplete documentation may delay the processing of this request.
- Prior authorization guidelines and quantity limits may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapters – **Lipotropics, Statins and Quantity Limits/Daily Dose Limits**, accessible on the Department's Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request: _____	Prescriber name: _____		
<input type="checkbox"/> Renewal request	(PA# _____)				
Name of office contact: _____			Specialty: _____		
Contact's phone number: _____			State license #: _____		
LTC facility contact/phone: _____		NPI: _____	MA Provider ID#: _____		
RECIPIENT INFORMATION			Street address: _____		
Recipient Name: _____		Suite #: _____	City/state/zip: _____		
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____		

### CLINICAL INFORMATION

<b>Non-preferred medication requested:</b>	<input type="checkbox"/> Atoprev tablet	<input type="checkbox"/> fluvastatin ER tablet	<input type="checkbox"/> Livalo tablet
	<input type="checkbox"/> atorvastatin/amlodipine tablet	<input type="checkbox"/> Lescol capsule	<input type="checkbox"/> Pravachol tablet
	<input type="checkbox"/> Caduet tablet	<input type="checkbox"/> Lescol XL tablet	<input type="checkbox"/> Zocor tablet
	<input type="checkbox"/> fluvastatin capsule	<input type="checkbox"/> Lipitor tablet	<input type="checkbox"/> _____
Strength: _____	Dose/directions: _____	Quantity: _____	Refills: _____
Diagnosis ( <i>submit documentation</i> ): _____		Dx code ( <i>required</i> ): _____	
1. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred Statins? <i>Check all that apply.</i> <input type="checkbox"/> atorvastatin tablet <input type="checkbox"/> pravastatin tablet <input type="checkbox"/> Crestor tablet <input type="checkbox"/> simvastatin tablet <input type="checkbox"/> lovastatin tablet <input type="checkbox"/> Vytorin tablet		<input type="checkbox"/> Yes – <i>submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.</i> <input type="checkbox"/> No	
2. Does the Recipient have results of a lipid panel drawn at baseline and after each of the preferred statins were started and doses increased?		<input type="checkbox"/> Yes <i>Submit all requested lipid panel test results.</i> <input type="checkbox"/> No	
3. What is the Recipient's goal LDL cholesterol?     goal: _____ mg/dL		<i>Submit documentation supporting this goal, such as medical history, family history of heart disease, tobacco use, and other risk factors.</i>	

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

Prescriber Signature: _____	Date: _____
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