pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

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	
☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:

☐Altoprev tablet
☐atorvastatin/amlodipine tablet
☐Caduet tablet
☐Crestor tablet
☐ezetimibe/simvastatin tablet
☐fluvastatin capsule
☐fluvastatin ER tablet
☐Lescol XL tablet
☐Lipitor tablet
☐Livalo tablet
☐Pravachol tablet
☐Zocor tablet
☐_____

Strength:	Dose/directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

1. Does the Beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred Statins? *Check all that apply.* ☐atorvastatin tablet ☐rosuvastatin tablet ☐lovastatin tablet ☐simvastatin tablet ☐pravastatin tablet ☐Vytorin tablet	☐Yes – *Submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.* ☐No
2. Does the Beneficiary have results of a lipid panel drawn at baseline and after each of the preferred statins were started and doses increased?	☐Yes ☐No *Submit all requested lipid panel test results.*
3. What is the Beneficiary's goal LDL cholesterol? goal: _____ mg/dL	*Submit documentation supporting this goal, such as medical history, family history of heart disease, tobacco use, and other risk factors.*

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

Prescriber Signature:	**Date**: