

LIPOTROPICS, OTHER PRIOR AUTHORIZATION FORM

- Please submit **all** requested documentation with this request. Incomplete documentation may delay the processing of this request.
- To review the prior authorization guidelines for Other Lipotropics, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Lipotropics, Other and Quantity Limits/Daily Dose Limits** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>).

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

CLINICAL INFORMATION

Non-Preferred Medication Requested: (For Repatha and Praluent, use PCSK9 Inhibitors form. For Juxtapid or Kynamro, use Juxtapid/Kynamro form.)			
<input type="checkbox"/> Antara	<input type="checkbox"/> Fibricor	<input type="checkbox"/> Omega-3 acid ethyl esters	
<input type="checkbox"/> Colestid	<input type="checkbox"/> Lipofen	<input type="checkbox"/> Questran/Questran Lite	
<input type="checkbox"/> Colestipol granules	<input type="checkbox"/> Lopid	<input type="checkbox"/> Triglide	
<input type="checkbox"/> Fenofibrate capsule (generic Antara, Lofibra, Lipofen)	<input type="checkbox"/> Lovaza	<input type="checkbox"/> Vascepa	
<input type="checkbox"/> Fenofibrate tablet (generic Fenoglide, Lofibra, Tricor)	<input type="checkbox"/> Niacin ER	<input type="checkbox"/> Welchol	
<input type="checkbox"/> Fenofibric acid (generic Fibricor, TriLipix)	<input type="checkbox"/> Niacor		
Strength:	Directions:	Quantity:	Refills:
Diagnosis:		Diagnosis code (required):	
1. Which of the following preferred agents in this therapeutic class has the Recipient tried & failed? Check all that apply.		<i>Submit medical record documentation, including baseline and follow-up cholesterol panels</i>	
<input type="checkbox"/> cholestyramine, cholestyramine lite, or Prevalite powder/packets <input type="checkbox"/> Tricor tablet <input type="checkbox"/> colestipol tablet <input type="checkbox"/> TriLipix capsule <input type="checkbox"/> gemfibrozil tablet <input type="checkbox"/> Zetia tablet <input type="checkbox"/> Niaspan tablet			
2. Does the Recipient have a contraindication or intolerance to any of the preferred agents listed in question (1)?		<input type="checkbox"/> Yes – <i>submit medical record documentation of contraindications/intolerances</i> <input type="checkbox"/> No	
**For Lovaza/Omega-3 acid ethyl esters requests, continue to next question. All other requests, submit to Pharmacy Services. **			
LOVAZA/OMEGA-3 ACID ETHYL ESTERS requests only			
1. What is the Recipient's triglyceride (TG) level? _____ mg/dL		<i>Submit results of recent cholesterol panel and ALT and medical record documentation of monitoring plan</i>	
2. Does the Recipient have baseline (before treatment) lab values for TGs, LDL-C, and ALT?			

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

Prescriber Signature:	Date:
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