



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit [go.covermymeds.com/OptumRx](http://go.covermymeds.com/OptumRx) to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

## Flolipid Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>	Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>		

Clinical Information (required)	
<b>Select the diagnosis below:</b>	
<input type="checkbox"/> Heterozygous familial hypercholesterolemia (HeFH)	
<input type="checkbox"/> Hyperlipidemia	
<input type="checkbox"/> Reductions in risk of CHD mortality and cardiovascular events	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	

<b>Clinical information:</b>
Is the patient unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to age, oral/motor difficulties, or dysphagia? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient utilize a feeding tube for medication administration? <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Select the medications the patient has a trial and failure, contraindication, or intolerance to:</b>	
<input type="checkbox"/> Atorvastatin	<input type="checkbox"/> Pravastatin
<input type="checkbox"/> Fluvastatin	<input type="checkbox"/> Rosuvastatin
<input type="checkbox"/> Fluvastatin extended-release (ER)	<input type="checkbox"/> Simvastatin
<input type="checkbox"/> Lovastatin	

<b>Quantity limit requests:</b>
What is the quantity requested per DAY? _____
Has the patient been taking the requested medication at the prescribed dose chronically? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient have evidence of myopathy (e.g., muscle pain, muscle tenderness, muscle weakness) while taking the requested medication at the prescribed dose? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>What is the reason for exceeding the plan limitations?</b>
<input type="checkbox"/> Titration or loading dose purposes
<input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
<input type="checkbox"/> Requested strength/dose is not commercially available
<input type="checkbox"/> Other: _____

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

Please note: This request may be denied unless all required information is received.  
For urgent or expedited requests please call 1-800-711-4555.  
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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