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

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:
- ❑ Heterozygous familial hypercholesterolemia (HeFH)
- ❑ Hyperlipidemia
- ❑ Reductions in risk of CHD mortality and cardiovascular events
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

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? ❑ **Yes** ❑ **No**

Does the patient utilize a feeding tube for medication administration? ❑ **Yes** ❑ **No**

Select the medications the patient has a trial and failure, contraindication, or intolerance to:
- ❑ Atorvastatin
- ❑ Fluvastatin
- ❑ Fluvastatin extended-release (ER)
- ❑ Lovastatin
- ❑ Pravastatin
- ❑ Rosuvastatin
- ❑ Simvastatin

Quantity limit requests:

What is the quantity requested per DAY? _____

Has the patient been taking the requested medication at the prescribed dose chronically? ❑ **Yes** ❑ **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? ❑ **Yes** ❑ **No**

What is the reason for exceeding the plan limitations?
- ❑ Titration or loading dose purposes
- ❑ 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)
- ❑ Requested strength/dose is not commercially available
- ❑ 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.