



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

Livalo® & Zypitamag 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 brand | Directions for Use: | |
| <input type="checkbox"/> Check if request is for continuation of therapy | | |

| Clinical Information (required) | |
|--|---------------------------------------|
| Select the diagnosis below: | |
| <input type="checkbox"/> Hyperlipidemia | |
| <input type="checkbox"/> Mixed dyslipidemia | |
| <input type="checkbox"/> Other diagnosis: _____ | ICD-10 Code(s): _____ |
| Select the medications the patient has a failure, contraindication, or intolerance to: | |
| <input type="checkbox"/> Atorvastatin | <input type="checkbox"/> Pravachol |
| <input type="checkbox"/> Ezetimibe-simvastatin | <input type="checkbox"/> Pravastatin |
| <input type="checkbox"/> Flolipid | <input type="checkbox"/> Rosuvastatin |
| <input type="checkbox"/> Fluvastatin | <input type="checkbox"/> Simvastatin |
| <input type="checkbox"/> Fluvastatin extended-release | <input type="checkbox"/> Zocor |
| <input type="checkbox"/> Lovastatin | |
| <input type="checkbox"/> Other generic statin. Please specify: _____ | |
| For Zypitamag requests, also answer the following: | |
| Has the patient had a failure, contraindication, or intolerance to Livalo? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Quantity limit requests: | |
| What is the quantity requested per DAY? _____ | |
| What is the reason for exceeding the plan limitations? | |
| <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"/> There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. Please specify: _____ | |
| <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.
 If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
 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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 Office use only: Livalo-Zypitamag_CMS_2019Jan-W