HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM

BRAND STATINS

Altoprev®, FloLipid®, Livalo®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Altoprev® (lovastatin extended-release), ☐ FloLipid® (simvastatin suspension), ☐ Livalo® (pitavastatin)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
ALTOPREV®			
1. Is the request for Altoprev®?	☐	☐	
2. Is the request for the treatment of primary hypercholesterolemia, primary or secondary prevention of cardiovascular events, or to slow coronary atherosclerosis progression?	☐	☐	**Please provide documentation**
3. Has the member had a 90 day trial and failure or intolerance of at least 4 other generic statin therapies (e.g. simvastatin, atorvastatin, etc.)?	☐	☐	**Please provide documentation**
4. Has the member had a 90 day trial and failure of ezetimibe?	☐	☐	**Please provide documentation**
FLOLIPID®			
1. Is the request for FloLipid®?	☐	☐	
2. Is the request for treatment of primary hypercholesterolemia, hypertriglyceridemia, primary dysbetalipoproteinemia, homozygous familial hyperlipidemia, primary or secondary prevention of cardiovascular events, or heterozygous familial hypercholesterolemia in adolescent patients?	☐	☐	**Please provide documentation**
3. Is the member unable to swallow or has severe dysphagia that prevents the member from taking solid oral dosage forms?	☐	☐	**Please provide documentation**

LIVALO®			
1. Is the request for Livalo®?	☐	☐	
2. Is the request for treatment of primary hypercholesterolemia or hypertriglyceridemia?	☐	☐	**Please provide documentation**
3. Has the member had a 90 day trial and failure or intolerance of at least 4 other high-intensity generic statin therapies (e.g. rosuvastatin, atorvastatin)?	☐	☐	**Please provide documentation**
4. Has the member had a 90 day trial and failure of ezetimibe?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the therapy shown to be effective with an improvement in condition?	☐	☐	**Please provide documentation**
3. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

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Policy PHARM-HCU-071
Origination Date: 01/01/2022
Reviewed/Revised Date: 07/29/2024
Next Review Date: 07/29/2025
Current Effective Date: 08/01/2024