Antihyperlipidemics – Adenosine Triphosphate-Citrate Lyase Inhibitors – Washington Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of therapy? ☐ Yes ☐ No
   If yes, does patient have clinical documentation demonstrating disease stability or a positive clinical response (e.g., decrease in LDL-C or achievement of patient LDL-C goal)? ☐ Yes ☐ No

2. Indicate patient's diagnosis:
   ☐ Established cardiovascular disease (CVD). Indicate the following for patient. Check all that apply:
      ☐ Coronary artery disease
      ☐ Symptomatic peripheral artery disease
      ☐ Cerebrovascular atherosclerotic disease
   ☐ High risk for CVD. Indicate the following for patient. Check all that apply:
      ☐ Reynolds Risk score > 30%; or SCORE Risk score > 7.5% over 10 years
      ☐ Coronary artery calcium score > 400 Agatston units (AU) at any time in the past
      ☐ Patients with Type 1 or Type 2 diabetes, aged > 65 years (women) or > 60 years (men)
      ☐ Framingham risk score ≥ 20% (high risk)
   ☐ Primary hyperlipidemia
   ☐ Heterozygous familial hypercholesterolemia (HeFH)
   ☐ Other. Specify: _____

3. Indicate the following for patient. Check all that apply:
   ☐ Has had trial of one high-intensity statin (i.e., atorvastatin ≥40 mg daily, rosuvastatin ≥ 20 mg daily) for a minimum trial of 12 weeks.
   ☐ Statin intolerant. Indicate the following for patient. Check all that apply:
      ☐ Experienced statin-related rhabdomyolysis along with end organ damage or myoglobinuria.
      ☐ Experienced skeletal muscle symptoms which occurred while receiving separate trials of both atorvastatin and rosuvastatin and symptoms resolved upon discontinuation of each medication.
      ☐ Other. Specify: _____
   ☐ Currently taking a maximally tolerated statin dose
   ☐ Maximally tolerated statin dose is contraindicated. Explain: _____

4. What is patient's low-density lipoprotein cholesterol (LDL-C)? _____mg/dL Date taken:_____

CHART NOTES ARE REQUIRED WITH THIS REQUEST

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Prescriber signature	Prescriber specialty	Date