



## Lipotropics, Statins Prior Authorization Appeal Form (Page 1 of 2)

**Note:** If the following information is NOT filled in completely, correctly, and/or legibly the appeal process will be delayed. **Please complete one form for each member.**

<b>Member Information</b> (required)			<b>Provider Information</b> (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:

<b>Medication Information</b> (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>			

<b>Clinical Information</b> (required)
<b>A COPY OF THE MEMBER'S LIPID PANELS MUST BE INCLUDED WHEN SUBMITTING (both Pre-Treatment LDL Value/Date and Current (within the past 60 days) LDL Value/Date are <u>required</u> to complete the review)</b>

**Select the diagnosis below:**

- Abdominal Aortic Aneurysm
- Acute Coronary Syndrome
- Carotid Artery Disease
- Coronary Heart Disease (CHD)
- Diabetes Mellitus
- Peripheral Arterial Disease
- Previous Coronary Event (Myocardial Infarction, Angina, Arrhythmia)
- Other diagnosis: \_\_\_\_\_

**Clinical information:**

Select if the member has any of the following risk factors:

- Age: Male (M) >45yrs, Female (F) >55yrs
- Cigarette smoking
- Family history of premature CHD in first degree relative: M <55yrs, F <65yrs
- HDL cholesterol: M <40 mg/dL, F <50 mg/dL
- Hypertension (≥130/≥85 mmHg or on HTN medication)
- Metabolic Syndrome

If the member has metabolic syndrome, select all applicable risk factors below:

- Abdominal obesity (waist circumference: M >40in, F >35in)
- BP ≥130/≥85 mmHg
- Fasting glucose ≥110 mg/dL
- HDL: M <40 mg/dL, F <50 mg/dL
- Triglycerides ≥150 mg/dL

