Fibric Acid Derivatives
Prior Authorization Request Form

JOHNS HOPKINS MEDICINE
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

PLEASE NOTE:

- **NO prior authorization is required for the preferred agents gemfibrozil (Lopid, generics), generic fenofibrate micronized/nonmicronized formulations (including Lofibra), and fenofibrate nanocrystallized (Tricor).** (Fenoglide is not covered under the TRICARE Pharmacy program.)
- **Antara, Fibricor, Lipofen, Triglide, and Trilipix are the non-preferred fibric acid derivative products.** Prior authorization for the non-preferred agents Antara, Fibricor, Lipofen, Triglide, and Trilipix is not required IF there has been a trial of a preferred fibric acid derivative (gemfibrozil, generic fenofibrate, Lofibra, Tricor) based on prescriptions filled during the last 180 days.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Does the patient have a contraindication to **generic fenofibrate, Lofibra, and Tricor** that is not expected to occur with the non-preferred fibric acid derivative?	☐ Yes Proceed to question 2	☐ No Coverage not approved
2. Does the patient have a contraindication to **gemfibrozil (Lopid)** that is not expected to occur with the non-preferred fibric acid derivative?	☐ Yes Sign and date below	☐ No Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

Implementation: 13 July 2011

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: