Prior Authorization Request Form for
fluvastatin extended-release **(Lescol XL),** pitavastatin **(Livalo),** pitavastatin magnesium (Zypitamag)

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.

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. Has the patient tried a preferred statin with similar LDL lowering (moderate or low intensity) and was unable to tolerate it due to adverse effects? *(the preferred statins are **atorvastatin, atorvastatin-amlodipine, fluvastatin immediate-release, lovastatin, pravastatin, rosuvastatin, and simvastatin**)*	☐ Yes Sign and date below	☐ No Proceed to Question 2
2. Is the patient taking a concurrent drug that is metabolized by the cytochrome P450 3A4 pathway?	☐ Yes Sign and date below	☐ No **STOP** **Coverage not approved**

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

_____ _____

Prescriber Signature Date

[26 April 2018]

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