

Fibric Acid Derivatives
Prior Authorization Request Form



JOHNS HOPKINS
M E D I C I N E

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HEALTHCARE

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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. 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?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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	
<input type="checkbox"/> Approved:	Duration of Approval: ____ month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: