

Lipotropics - Statins

Phone: 215-991-4300
Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:		Prescriber Name:	
HPP Member Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Primary Phone:	NPI:	PA PROMISe ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>HPP's maximum approval time is 12 months but may be less depending on the drug.</i>			

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this a request for a preferred statin drug (e.g., atorvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin)?

 Yes

 No

Q2. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred statin drugs (e.g., atorvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin)?

 Yes

 No

Q3. Is this a request for a statin drug when there is a record of a recent paid claim for another statin (i.e., potential therapeutic duplication)?

 Yes

 No

Q4. Is the patient being titrated to, or tapered from, a drug in the same class?

 Yes

 No

Q5. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

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Member Name:	Prescriber Name:
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<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Q6. Additional Information:

Prescriber Signature

Date

v2025