Antihyperlipidemics – Adenosine Triphosphate-Citrate Lyase Inhibitors

Please fax this completed form to (833) 645-2734 OR mail to: Centene Pharmacy Services | 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

Coordinated Care of Washington, Inc. (Apple Health) Preferred Drug list: https://www.coordinatedcarehealth.com/content/dam/centene/centene-pharmacy/pdl/FORMULARY-CoordinatedCare_Washington.pdf

For policy criteria, see: https://www.coordinatedcarehealth.com/content/coordinatedcare/en_us/providers/resources/clinical-payment-policies.html/

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of therapy? ☐ Yes ☐ No
   If yes, does patient have clinical documentation demonstrating disease stability or a positive clinical response (e.g., decrease in LDL-C or achievement of patient LDL-C goal)? ☐ Yes ☐ No

2. Indicate patient's diagnosis:
   - ☐ Established cardiovascular disease (CVD). Indicate the following for patient. Check all that apply:
     - ☐ Coronary artery disease
     - ☐ Symptomatic peripheral artery disease
     - ☐ Cerebrovascular atherosclerotic disease
   - ☐ High risk for CVD. Indicate the following for patient. Check all that apply:
     - ☐ Reynolds Risk score > 30%; or SCORE Risk score > 7.5% over 10 years
     - ☐ Coronary artery calcium score > 400 Agatston units (AU) at any time in the past
     - ☐ Patients with Type 1 or Type 2 diabetes, aged > 65 years (women) or > 60 years (men)
     - ☐ Framingham risk score ≥ 20% (high risk)
   - ☐ Primary hyperlipidemia
   - ☐ Heterozygous familial hypercholesterolemia (HeFH)
   - ☐ Other. Specify: _____

3. Indicate the following for patient. Check all that apply:
   - ☐ Has had trial of one high-intensity statin (i.e., atorvastatin ≥40 mg daily, rosuvastatin ≥ 20 mg daily) for a minimum trial of 12 weeks.
   - ☐ Statin intolerant. Indicate the following for patient. Check all that apply:
     - ☐ Experienced statin-related rhabdomyolysis along with end organ damage or myoglobinuria.
     - ☐ Experienced skeletal muscle symptoms which occurred while receiving separate trials of both atorvastatin and rosuvastatin and symptoms resolved upon discontinuation of each medication.
     - ☐ Other. Specify: _____
   - ☐ Currently taking a maximally tolerated statin dose
   - ☐ Maximally tolerated statin dose is contraindicated. Explain: _____

4. What is patient's low-density lipoprotein cholesterol (LDL-C)? _____mg/dL Date taken:_____

CHART NOTES ARE REQUIRED WITH THIS REQUEST		
Prescriber signature	Prescriber specialty	Date

Centene Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)