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

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

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:

Question		
1. DoD's preferred statins are atorvastatin, fluvastatin immediate-release, lovastatin, pravastatin, rosuvastatin, and simvastatin. These formulary agents are available for DoD beneficiaries without a prior authorization.	☐ Acknowledged Proceed to question **2**	
2. Has the patient tried a preferred statin (i.e. atorvastatin, fluvastatin immediate-release, lovastatin, pravastatin, rosuvastatin, and simvastatin) with similar LDL lowering (moderate or low intensity) and was unable to tolerate it due to adverse effects?	☐ Yes **Sign and date below**	☐ No Proceed to Question **3**
3. 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

[14 August 2020]