Fenofibrate Step Therapy

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM
BlueChoice® HealthPlan

Patient Information	
Name:	**Insurance ID #:**
Address:	**Birthdate:**

Provider Information	
Physician's Name:	**Physician DEA #:**
Phone:	**Fax:**
Office Address:	
Diagnosis:	**ICD-9 Code:**

When this form is completed, please fax back to Caremark at 888-836-0730.

This fax machine is located in a HIPAA-compliant secure location.

Call Caremark at 800-294-5979 with any questions concerning prior authorization procedures.

On behalf of BlueChoice HealthPlan, Caremark assists in the administration of this program. Caremark is an independent company that administers prescription drug benefits.

1. Is this request is for Trilipix? [If the answer to this question is no, skip to question 3.] Y N
2. Is the member currently taking a statin? [If answer to this question is yes, then no further questions required.] Y N
3. Is there a history of intolerance, significant adverse reaction or non-response to a generic fibrate? Y N

Comments: ______________________________

Information on this form is accurate as of the date below.

Prescriber's Signature:	**Date:**

BlueChoice HealthPlan is an independent licensee of the Blue Cross and Blue Shield Association.