Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Statin Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for quantities greater than 30 units per month for all statins. In addition to the quantity limits, PA is required for Advicor, Altocor, Mevacor, Pravachol, and Zocor. **PA will not be required for quantities less than or equal to 30 units per month for Crestor, Lescol, Lescol XL, Lipitor, or generic lovastatin.** Additional information about statins can be found within the MassHealth Drug List at **www.mass.gov/masshealth.**

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m

Member's place of residence ☐ home ☐ nursing facility

Medication information

Please complete if the request is for quantities greater than 30 units/month.

Statin request	Quantity per month
☐ Advicor	_____
☐ Altocor	_____
☐ Crestor	_____
☐ Lescol	_____
☐ Lescol XL	_____
☐ Lipitor	_____
☐ lovastatin	_____
☐ Mevacor (brand name)	_____
☐ Pravachol	_____
☐ Zocor	_____

Dose, frequency, and duration of requested drug

Drug or service code

Indication for statin requested (Check one or all that apply.)

☐ Hypertriglyceridemia ☐ Primary hypercholesterolemia
☐ Mixed dyslipidemia ☐ Secondary prevention of cardiovascular event
☐ Other. Specify pertinent medical history, diagnostic studies, and/or laboratory results.

_____
_____
_____
_____
_____
_____

Section I Please complete Section I if your request is for more than 30 units per month.

Please provide a rationale for requested dose quantity and frequency, including a detailed treatment plan. (Specify pertinent medical history, diagnostic studies and/or lab results.)

_____
_____

Is member a candidate for dose consolidation? (e.g., member is on Lipitor 10 mg BID, and dose can be consolidated to Lipitor 20 mg QD, **which does not require PA**). ☐ Yes ☐ No

Please provide rationale for a regimen of greater than one unit per day. _____
_____

over ▶

Medication information (cont.)

Section II Please complete Section II if your request is for Advicor, Altocor, Mevacor (brand name), Pravachol, or Zocor.

Has member tried two of the following statins: Crestor, Lescol/Lescol XL, Lipitor, or generic lovastatin?

☐ Yes. Complete boxes A and B.

☐ No. Explain why not.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

A. Drug name

Dates of use | Dose and frequency

Did member experience any of the following?

☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

_____

_____

B. Drug name

Dates of use | Dose and frequency

Did member experience any of the following?

☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

_____

_____

Note: You may be asked to provide supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date