

OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations. Visit go.covermymeds.com/OptumRx to begin using this free service

Antara[®], Fenoglide[®], Fibracor[®], Lipofen[®], Tricor[®], Triglide[®] & Trilipix[®] Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

This form may be faxed to 844-403-1029.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP:	Office Street Address:		
Phone:			City:	State:	ZIP:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
			Directions for Use:		
Clinical Information (required)					
1. Does the patient have a documented contraindication to or a potential drug interaction with a generic fibrate?					<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has the patient had a trial and was intolerant to at least one generic fibrate?					<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has the patient demonstrated an inadequate treatment response after at least a 30-day trial of a generic fibrate?					<input type="checkbox"/> Yes <input type="checkbox"/> No

Information on this form is accurate as of this date.

Prescriber's Signature:	Date:
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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note:

This request may be denied unless all required information is received.

For more information about the prior authorization process, please contact us at 855-811-2218.
Monday – Friday: 8 a.m. to 1 a.m. Eastern, and Saturday: 9 a.m. to 6 p.m. Eastern

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